TRANSFORMATION OF THE MEDICAID PROGRAM—Part 3

HEARINGS

BEFORE THE

SUBCOMMITTEE ON
HEALTH AND ENVIRONMENT

OF THE

COMMITTEE ON COMMERCE
HOUSE OF REPRESENTATIVES

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TRANSFORMATION OF THE MEDICAID PROGRAM

WEDNESDAY, JULY 26, 1995

HOUSE OF REPRESENTATIVES,
COMMITTEE ON COMMERCE,
SUBCOMMITTEE ON HEALTH AND ENVIRONMENT,
Washington, DC.

The subcommittee met, pursuant to notice, at 9:08 a.m., in room 2322, Rayburn House Office Building, Hon. Michael Bilirakis (chairman) presiding.

Members present: Representatives Bilirakis, Hastert, Barton, Stearns, Burr, Bilbray, Ganske, Bliley (ex officio), Waxman, Brown, Lincoln, Deutsch, Stupak, Wyden, Hall, Bryant, Towns, and Pallone.

Staff present: Howard Cohen, majority counsel; Mary M. McGrane, majority counsel; Melody Harned, majority counsel; Eric Berger, professional staff; Bridget Taylor, minority professional staff; and Chris Knauer, minority investigator.

Mr. BILIRAKIS. The hearing will come to order. I want to, at the outset, announce that, I would hope that all of you know this by now, but we have the President of South Korea, in joint session in the House Room. We will break this meeting about 10:45 and not convene again until 1 p.m.

I expect we probably will complete the first panel by then, but those of you in the subsequent panels ought to take heed of that and possibly you may have other things you may want to do the rest of the morning.

Today's hearing provides us with the opportunity both to build on our discussions of past weeks and to look forward toward the future of the Medicaid program. In recent hearings, we have heard testimony about Medicaid's explosive cost and administrative complexity. State Governors, Medicaid directors, administration officials and technical experts have described how the program grew to its current size and have illustrated for us how ineffective past efforts have been at bringing the program under control.

The news about Medicaid is not all bad, however. Today we will hear from witnesses who will speak to an issue that is central to our examination of Medicaid reform, and that is the role that the States can and will play in improving the quality, effectiveness and efficiency of the health care we provide to America's most disadvantaged citizens.

I think what we will hear today will serve to remind many of us that States can bring to Medicaid a level of caring and innovation that the program has lacked for far too long. Unfortunately, States

still have little operational or administrative flexibility in the Medicaid program. As a result, Governors and other State officials have long complained that Medicaid has served as an obstacle, rather than as an opportunity to developing innovative health care delivery strategies and they have had to watch, almost from the sidelines, as Medicaid has consumed more and more of their State budgets.

Since the beginning, the Medicaid program has grown at virtually uncontrollable rates. In 1966, Medicaid cost the Federal Government only $800 million. Today, according to the Congressional Budget Office, Medicaid costs the Federal share more than 100 times, more than 100 times that amount, $89.2 billion in fiscal year 1995. Even more alarming than the program's expenditure growth to date are CBO's estimates of Medicaid spending in the next 7 years. If the program is not significantly reformed, CBO expects Federal Medicaid spending to soar from $89.2 billion in fiscal year 1995 to $177.8 billion in fiscal year 2002.

At the same time, State Medicaid spending will climb from $74.9 billion in fiscal year 1996 to $134.1 billion in fiscal year 2002. I believe that figure is probably intended to be 1995.

With Medicaid already the single largest program in virtually every State budget, the program's projected growth raises the prospect of severe financial crises in the States. Already Medicaid spending has prevented the growth of State investments in education, child welfare services, law enforcement and public transportation.

As we have focused on the peril facing the Medicaid program, it has become increasingly clear that the Federal Government bears much of the blame. Federal mandates fueled the expansion of the Medicaid eligible population and the cost of the program. In addition, States have been forced to comply with complex Federal regulations and increase their spending levels in order to receive the Federal share of Medicaid spending.

In addition, many States have charged that the Health Care Financing Administration has served as a hindrance rather than a help in their efforts to get control of Medicaid spending. HCFA is supposed to work with State Medicaid departments to ensure appropriate management of the Medicaid program. However, the reality of HCFA's State relations appears to be less a matter of coordinated cooperation than it is an example of Federal micromanagement of State affairs.

Not surprisingly, many States have sought to take advantage of one of the only forms of relief available to them, and that is the demonstration waiver permitted by section 1115 of the Social Security Act. Here, too, though, States have been frustrated. The section 1115 waiver process is costly, complex and time-consuming. In spite of these challenges, 23 States have submitted waiver applications. To date, however, only 10 have been granted permission to do what States already claim they have a right to do, and that is to administer their medical assistance programs in the manner that best meets the needs of their residents.

It is because of State frustration with the inflexibility of the current Medicaid program and the ineffectiveness of the section 1115 waiver process that Congress is considering significant Medicaid

reform. Under the proposed block grant reform initiative, Medicaid would become a State-driven program. As a result, the Medicaid program would enable States to develop innovative service delivery strategies and efficient administrative practices.

Clearly, this step represents a major change from the current Medicaid program, but if we pledge ourselves to anything in this debate, it must be that we will address these issues with open minds and without rancor. I cannot help but recall the Vice President's testimony before this subcommittee in 1991 when we were examining the Oregon managed care plan. At that hearing, then Senator Gore charged that Oregon was making "a tragic choice and a horrible mistake" that would result in the death of countless poor babies.

He charged that "A child whose mother depends on Medicaid who must have costly medical care or die might be allowed to die. But a child in the very next bed with the very same diagnosis and prognosis whose mother is a State legislator would be treated." So as will be clear when we hear from Ms. Jean Thorne, Oregon's Medicaid Director, later today, Mr. Gore's volatile statements were inaccurate and certainly unfair.

It's my hope that we will show the expert witnesses who have joined us today the courtesy of our attention and our consideration. I apologize for the lengthy opening statement and would yield now to the gentleman from California, Mr. Waxman.

[The attachment to the prepared statement of Hon. Michael Bilirakis follows:]

WHO WILL SAVE THE COCAINE BABIES

[Washington Times—May 14, 1995]

By Charles Condon

Walk into any neo-natal care hospital unit in America and your heart will be broken by the sight of infants shaking uncontrollably in the agonizing pain caused by their mothers' addictions to crack cocaine.

One of every 10 babies born in America today is exposed to cocaine in the womb. Many of these children die soon after delivery. Those that survive are far more likely than other infants to be afflicted by serious behavioral problems, birth defects and learning disabilities.

This tragedy doesn't have to happen. We can significantly reduce such child abuse. I know, because in 1989 I helped start one of the nation's first effective crack-baby prevention programs at Charleston's Medical University of South Carolina (MUSC).

Incredibly, the Clinton administration stopped the MUSC program even as it was becoming a model for hospitals across the nation. The reason: The government says protecting the "privacy rights" of crack-snorting mothers is more important than preventing abuse of their unborn babies, or themselves.

That's right. A swarm of federal officials from the U.S. Department of Health and Human Services (HHS)—aided and abetted by radical feminist activists aligned with the American Civil Liberties Union (ACLU)—descended on MUSC in 1993 making unfounded allegations of discrimination and accusing the hospital of violating the privacy rights of the addicted mothers. After listening to the arguments of federal officials, it became clear that our program was unacceptable because it used law enforcement to induce responsible behavior among drug-addicted women, most of whom happened to be black. A civil rights lawsuit was pending, the bureaucrats warned, and $54 million in federal funding—about 60 percent of MUSC's total annual budget—would be lost if the crack babies program was not terminated.

Facing such massive federal and judicial attacks, MUSC officials had no choice but to stop a program that was saving lives of mothers and children, and preventing horrible suffering.

Before 1989, an average of 24 pregnant mothers entering the hospital each month tested positive for cocaine use. Despite efforts by MUSC's staff to educate them on

the damage they were doing to themselves and their unborn babies, virtually none of these women was willing to enter a drug treatment program voluntarily. As a South Carolina circuit solicitor, I worked with MUSC officials, local police and judges, and drug rehabilitation experts to launch a tough amnesty program that gave the pregnant mothers a simple choice: Stop using cocaine immediately and get professional help, or face prosecution.

We offered immunity from prosecution, free medical services for the mothers and their babies, and free access to a drug rehabilitation program. All we asked in return was that the women enter the program in good faith and stop abusing their unborn children with drugs.

Soon after the program started, the number of pregnant women testing positive for cocaine use dropped to five or six a month—a 75 percent decrease. Every woman who entered the program signed a consent form to be tested. Prenatal visits, as well as live births at the hospital, stayed the same as before, which was widely publicized in the state. Among those working with the hospital was Charleston's black police chief, Reuben Greenberg, who said he "was glad that somebody was finally doing something to help kids in the black community." Among the most fervent advocates of the MUSC program were drug rehabilitation counselors, and experts, who assured us the effort would fail unless the addicted mothers were forced to be responsible.

But that wasn't good enough for bureaucrats at HHS, who, after several investigations, said, "It is the government's obligation to ensure that federal funds do not support a program which discriminates." At the same time, the New York-based ACLU offshoot, the Center for Reproductive Law and Policy (CRLP) filed a civil suit against the hospital alleging racial discrimination and violations of the 14th Amendment to the U.S. Constitution.

"It was obvious to us that there was collusion between the CRLP and all the federal agencies that came down on us," says MUSC's president, Dr. James Edwards. The CRLP's suit, filed on behalf of five women who tested positive for cocaine while pregnant, is still pending. They want $3 million.

Meanwhile, others like MUSC nurse Shirley Brown see crack babies being born and suffering: "You just have to sit around with your hands tied and watch them destroy a baby."

If a mother injected cocaine into the tiny arm of her infant, causing permanent brain damage or death, certainly that mother would be arrested and prosecuted. That is exactly what addicted mothers do when they consume cocaine throughout their pregnancies. In South Carolina, we tried to do something about it, but were stopped by federal bureaucrats who act as if they are deaf to the cries of damaged babies.

Why is the Clinton administration stopping us from protecting our children?

Mr. WAXMAN. Thank you very much, Mr. Chairman. This is the fourth in a series of hearings that attempts to avoid the real issues before this subcommittee; how are the States going to deal with the Republican Medicaid budget, which will cut Federal funding by $182 billion over the next 7 years; how are those losses, which will average 29 percent in the year 2002 alone, going to be divided among the States?

Today's hearing should be on the actual Republican bill, the block grant Medicaid, but the Republican bill is not public and it doesn't appear that it will be public until after Labor Day, giving this committee just 14 days to review and vote on the most fundamental and far-reaching changes in Medicaid in 30 years.

Of course, this is the same 14 days during which the Republicans also expect us to review and vote upon their still secret proposals to slash $270 billion out of the Medicare program. Obviously, Republicans want as few people as possible to understand what they're trying to do, because what they're trying to do is to end the 30-year-old guarantee of health and long-term care coverage to 36 million Americans and to do that in a way that the States will be left holding the bag.

Of course, some States will be holding larger bags than others, but we can't tell which ones yet because we haven't seen the Re-

publican bill which will lay out the distribution of Federal Medicaid block grant funds among the States. What we do know is that the stakes are enormous for the States, for hospitals and nursing homes, and for the beneficiaries. And in order to be a beneficiary under Medicaid, you not only have to be poor, you have to be among the poorest of the poor.

The Republicans don't want to talk about this, nor do they want to talk about how their $182 billion in Medicaid cuts will force the States to deny coverage to millions of Americans.

I have some charts and chart one shows the number of Americans who will lose coverage in the year 2002 alone in the States that are appearing before us this morning. These estimates were prepared by economists at the Urban Institute, using very conservative assumptions. The Republican message this morning is that innovation will enable the States to handle the loss of $182 billion in Federal funds without hurting people. The truth is innovation can't possibly save $182 billion in Federal Medicaid funds over the next 7 years. Only benefits and eligibility cuts can achieve targets that excessive.

In fact, the Republican Medicaid cuts will gut innovation, not promote it. As chart two shows, the innovator States, like Arizona, Florida, Oregon and Tennessee, have annual rates of growth in Federal matching well in excess of the 4 percent that would be allowed under the Republican cuts.

I believe in innovation. I believe that we ought to be looking for more effective ways to deliver high quality health and long-term care to vulnerable Americans. But I do not believe that we need to block grant the Medicaid program, strip over 30 million Americans of guaranteed health care coverage, and slash Federal spending to the States in order to innovate, because by doing so, the Republican Medicaid budget will start a race to the bottom among the States.

This is not a race that will be won by the innovator States. It is a race that will be won by the terminator States, those that cut back most deeply on eligibility and benefits, encouraging their sick to relocate to other States for coverage and discouraging Americans from other States from moving in.

I'm afraid that if the Republican Medicaid cuts are enacted, innovation will become a code word for rationing by the States, rationing forced on them by reductions in Federal dollars, and that real innovation of the kind now occurring under some of the Medicaid demonstration waivers will be aborted.

I look forward to the opportunity to explore these issues with our witnesses today and to working to see that we don't do harm to those people that are looking to us to keep the Medicaid program a viable option to give them the care they need.

Thank you, Mr. Chairman.

[The charts referred to follow:]

Republican $182 Billion Medicaid Cut

Coverage Losses in 2002

Even If States Must Continue to Match

Arizona	47,900
Oregon	66,600
S. Carolina	66,000
Tennessee	106,600
Texas	296,600
Virginia	141,300

???

How the Republican Medicaid Budget Guts Innovation

States With Medicaid Innovation Waivers	Growth in Federal Spending Needed for Innovation
Arizona	17%
Florida	16%
Oregon	16%
Tennessee	7%
Limit on Growth in Federal Funds Available for Innovation Under Republican Medicaid Budget Cuts:	**4%**

Mr. BILIRAKIS. Thank you, Mr. Waxman. Dr. Ganske.

Mr. GANSKE. Thank you, Mr. Chairman, for calling this hearing today. I am pleased to join you and the rest of the subcommittee as we continue to identify what is right and what is wrong in the Medicaid program.

Today we will learn about a number of State and local initiatives to improve the delivery of quality health care to poor and underserved populations. Unfortunately, we will also learn how outdated Federal rules and overzealous regulators have forced some of these programs to be discontinued.

The witnesses today will confirm what virtually every American knows and what HCFA has been reluctant to admit: local initiatives to problems yield innovative solutions with less bureaucracy. As we look to slow the growth of Medicaid, Congress should not fear the result of variable local programs. We should welcome the opportunity to empower States, counties and cities to develop new ways to provide health care to the poor and disabled.

Mr. Chairman, I look forward to the testimony we will hear today and to working constructively on Medicaid reform proposals which will remove many of the shackles under which the States must operate.

I yield back my time. Thank you.

Mr. BILIRAKIS. Thank you, Dr. Ganske. The gentleman from Michigan, Mr. Stupak.

Mr. STUPAK. Thank you, Mr. Chairman. I appreciate the opportunity to hear more about what the States are doing in the Medicaid program. At the same time, I hope we will hear what the States would do if Congress turns the Medicaid program into a block grant, because as I've said at previous hearings, I have some serious concerns about how this is going to be accomplished.

One of the concerns I have is how the States would finance long-term care. As you know, approximately 60 percent of Medicaid spending is for seniors and nursing homes and for blind and disabled who need long-term care. Half of the Nation's nursing home costs are paid for by Medicaid. Naturally, as our population gets older, the need for long-term care is going to be even greater.

One of my concerns is that the States will cut funding for long-term care at the time when the number of elderly and disabled is projected to rise sharply. Only one bill has actually been introduced to replace the Medicaid program with a block grant. I want to call your attention to Senator Ashcroft's bill, which is Senate Bill 844, because I think it represents the kind of problems we're going to have with a block grant program.

Senate Bill 844 imposes almost no conditions on how States can spend Federal money and it doesn't even require the States to contribute to the program. It makes no specific mention of long-term care and it would allow States to apply up to 30 percent of the Federal Medicaid contribution to other so-called welfare programs.

In its April 1995 report to the chairman of the House Budget Committee about restructuring the Medicaid program, the General Accounting Office said that while using block grants would allow for greater control over Federal expenditures and could increase States' administrative flexibility, the GAO went on to state, "On the other hand, unless State contributions were required, some

have predicted that substantial reductions in current State Medicaid spending would almost certainly occur. Also, since States would be responsible for 100 percent of the additional cost, this approach would put them at a greater risk for controlling program spending." I believe that there are a lot of unanswered questions about how such a block grant program would work. What I want to know is if we block grant this program and give money to the States, which of these programs are they going to change and how many people who are currently covered are going to lose their coverage. I want to know if the States are going to provide coverage to low income infants, children and pregnant women. I want to know if the States are going to pay premiums, co-payments, and deductibles for low income seniors.

Are they going to pay for prescription drugs, nursing homes, home and community-based long-term care? Are they going to continue to cover people with severe disabilities, including mentally retarded or permanently injured children and adults and the chronically mentally ill?

At some point, States are going to have to decide who gets covered and who does not. Before this Congress turns this program over to the States, I want to know how a block grant program will be administered. So I look forward to hearing from our witnesses today about how they propose to handle such a program and the issues I've raised.

Thank you, Mr. Chairman. I yield back the balance of my time.

Mr. BILIRAKIS. I thank the gentleman.

[The prepared statements of Hon. Thomas J. Bliley, Jr., and Hon. Brian P. Bilbray were received for the record:]

PREPARED STATEMENT OF HON. THOMAS J. BLILEY, JR., CHAIRMAN, COMMITTEE ON COMMERCE

It is a great pleasure to open this hearing on the Transformation of the Medicaid Program. I commend the Chairman for bringing together today's panel of experts and look forward to hearing their perspective on what is wrong with the current Medicaid program and what we can do to fix it.

I would also like to offer a personal welcome to Kay James, Virginia's Secretary of Health and Human Resources. Secretary James served as Governor Allen's principal architect in crafting the Virginia Independence Program—the most innovative and comprehensive welfare reform plan enacted in the nation to date

We have heard in past hearings that Medicaid is too costly, complex, and bureaucratic. And we have heard that increased flexibility can significantly improve the Medicaid program's effectiveness and efficiency.

But Medicaid flexibility offers States a vital human opportunity, as well. With increased operational and administrative flexibility, every State would be free to implement the principles of empowerment that have already made Virginia's welfare reform initiative a success. And that would result in a more inclusive and more proactive system of low-income medical assistance.

PREPARED STATEMENT OF HON. BRIAN P. BILBRAY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mr. Chairman, I would like to commend you for holding this hearing on the transformation of the Medicaid program which will focus on innovative approaches to providing care to low-income people throughout this country.

As I read from Governor Symington's testimony, Arizona has been able to initiate a unique program under the Section 1115 waiver in which managed care has played a vital role. I am impressed with Arizona's ability to provide health and long-term care services in a managed care framework to its entire Medicaid population.

However, although Arizona has been able to bring about changes under the Section 1115 waiver, it is not a guarantee for innovation. States, under a block grant

system, would be given the flexibility to create programs such as the one initiated in Arizona.

Being from the neighboring state of California, there are two issues that both California and Arizona are facing which I would like to address.

The first one deals with the growing population that both states face. I read from the testimony of Mable Chen, the Director of the Arizona Health Care Cost Containment System, that the Census Bureau estimates that Arizona's population will grow at twice the national average over the next ten years. My state of California is also a high-growth state and will be facing the same problem of how to serve this increasing population.

The second point I would like to make deals with the issue of illegal aliens that are being served under the current Medicaid system. Border states such as California and Arizona have increasingly been forced to cover the cost of providing care for this population.

When John Rodriquez, Deputy Director of the Medi-Cal program testified before this committee, he estimated that $600 million was spent by the state of California to pay for the health care of illegal aliens. Securing our borders is a federal responsibility. Any block grant proposal should include compensation for states who are carrying out the federal requirements for providing care to illegal aliens.

Factors such as states with a high percentage of growth as well as those with a large percentage of illegal immigrants must be provided for in the distribution of a block grant.

I look forward to the oral testimony of Governor Symington and the other witnesses and I yield back the balance of my time.

Mr. BILIRAKIS. Our first panel consists of the Honorable Fife Symington, Governor of Arizona. He is accompanied by Dr. Mabel Chen, Director of the Arizona Health Care Cost Containment System, who will also add to Governor Symington's testimony; and the Honorable Kay C. James, Secretary of Health and Human Resources of the Commonwealth of Virginia; the Honorable Charles Condon, Attorney General of South Carolina; and, Mr. Bruce Vladeck, Administrator of HCFA.

We will start off with Governor Symington. Obviously, as usual, your written statements will be made a part of the record. I am going to put a 5-minute light on here and hope that you will try to stay as close to that 5 minutes as possible.

Governor, let's kick off with you.

STATEMENTS OF FIFE SYMINGTON, GOVERNOR, ARIZONA, ACCOMPANIED BY MABEL CHEN, DIRECTOR, ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM; KAY COLES JAMES, SECRETARY, HEALTH AND HUMAN RESOURCES, COMMONWEALTH OF VIRGINIA; CHARLES MOLONY CONDON, ATTORNEY GENERAL, SOUTH CAROLINA; AND, BRUCE C. VLADECK, ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION

Mr. SYMINGTON. Thank you, Mr. Chairman and members of the subcommittee. Arizona appreciates the opportunity to share with you our unique experience in providing health care to its Medicaid population. I'll be giving an overview and Dr. Mabel Chen, the Director of our Medicaid program, will offer more detail on some of the points that I will make.

Our program, the Arizona Health Care Cost Containment System, which we call AHCCCS, is a State-conceived managed care program. As the subcommittee considers Medicaid block grant proposals, AHCCCS should serve as a positive example of the kind of program States could implement if they were freed from the regulatory constraints of the traditional title 19 program.

In its 13th year of operation, AHCCCS provides health and long-term care to title 19 eligible individuals. AHCCCS operates under a section 1115 Federal waiver, which provides the State relief from a number of Federal requirements without which the system could not have been implemented nor could it continue. AHCCCS also serves as an example of a high quality, cost-effective health care system that has garnered the support of Arizona citizens, providers, advocates, recipients and taxpayers. AHCCCS is accepted in Arizona without controversy as the method for delivering health and long-term care to the State's low income population.

Until October 1, 1982, Arizona was the only State in the Nation without a Medicaid program. Prior to that time, health care for the indigent was provided and fully funded by Arizona's 15 counties. In 1981, the State legislature and the Governor recognized that the counties could not continue to pay the full cost for health care and began to explore various options which would, for the first time, bring Federal Medicaid dollars to the State.

Central to these discussions was a determination by State leaders to create a managed care system which could deliver quality services, control costs, discourage the use of emergency rooms for primary care, and avoid fraud and abuse practices which are reported in fee-for-service programs.

In 1981, the legislature created AHCCCS as the first state-wide Medicaid managed care system in the Nation based on prepaid, capitated arrangements with health plans. In July 1982, HCFA approved the AHCCCS program as a 3-year research and demonstration waiver. The waiver has been renewed by HCFA since then. The most recent extension of AHCCCS, it can now operate until October 1, 1997.

The subcommittee should know that AHCCCS did not initially cover all Medicaid services. AHCCCS, in its early years, only focused on the provision of medical and acute provided through prepaid capitated health plans. Long-term care was added in 1989 through the Arizona Long-Term Care System after the medical program had stabilized. Modeled on a managed care approach, long-term care is bundled with medical care services and is provided through prepaid, capitated program contractors.

A phase-in of mental health services began then in 1990 and will be completed on October 1 of this year. It's important for the subcommittee to understand that AHCCCS provides health and long-term care services in a managed care framework to its entire Medicaid population; children, pregnant women, children and adults with chronic illnesses and disabilities, the elderly, families, the medically indigent medically needy, with 100 percent State funds, I might add, individuals who are eligible for both Medicaid and Medicare, the seriously mentally ill, physically and developmentally disabled persons.

Managed care in Arizona is fully implemented in both rural and urban areas for Medicaid beneficiaries. AHCCCS does not achieve cost control through a limited benefit package. Our health plans and program contractors provide the full Medicaid benefit package comparable to that of other States. Health plans fully comply with the EPSDT screening and follow-up treatment requirements. AHCCCS achieves cost control through its health plans and pro-

gram contractors who receive the prepaid amount per member for each month the individual is enrolled, regardless of the services a member uses.

In long-term care, this means program contractors receive the same amount whether an elderly person is served in his or her home or in a nursing facility. Most of our elderly and disabled prefer to receive care in their homes. Similarly, in the AHCCCS health care program, health plans receive the same monthly capitation amount whether a member is in the hospital or is treated in the physician's office.

AHCCCS does have a reinsurance program for high cost cases, which provides additional funds to health plans once a specified threshold is met.

Today, AHCCCS is accepted as cost-effective and innovative. The subcommittee does not have to rely on my observations or those of Dr. Chen, since AHCCCS has been the subject of very intense scrutiny. In fact, the Federal Government itself studied AHCCCS for the first 11 years of the program and came to the conclusion that AHCCCS saves money, provides greater access to care than traditional programs, and provides a higher quality of service.

The managed care features of the program coupled with market-based competition have produced substantial cost savings for Arizona and Federal taxpayers. When compared to a traditional Medicaid program, the AHCCCS health care program has saved 7 percent each year of its existence since 1982. When compared to a traditional Medicaid long-term care program, the Arizona Long-Term Care System has saved taxpayers 17 percent each year since 1990.

Increased competition among commercial and other organizations for the AHCCCS population continues to drive down the capitation rates. This competition reflects the profitability of our health plans, which is comparable to national averages for managed care organizations.

In 1994, AHCCCS received an unprecedented 95 proposals from 21 different organizations to serve its members and as a result of this competition, capitation rates per person were reduced 8 percent over the previous year. It's important to note that our hospital industry remains financially strong in Arizona, showing profitability above national standards. In part, this reflects that hospitals do well under the AHCCCS program.

Mr. Chairman, I see the red light on. I'll move right to my conclusion, because I have submitted this testimony to you in its fullest form.

Mr. BILIRAKIS. I appreciate that, sir.

Mr. SYMINGTON. I'd just like to say that my support for Medicaid block grants is based on the flexibility that it will provide Arizona and other States to take advantage of the local market and design creative State-initiated solutions to problems; to customize their programs in line with local market realities rather than the one-size-fits-all approach inherent in the Medicaid program today; to redirect administrative resources now devoted to Federal regulatory requirements to monitor the system and outcomes of care for new benefits or savings; and, to further steps to eliminate the institutional bias of the Medicaid program by offering enhanced community-based services in long-term care and mental health programs

and to free the State from the Boren amendment requirements that tie payments to provider costs. This requirement impacts fee-for-service payments made by AHCCCS to providers, not payments made under managed care.

Mr. Chairman, we are very pleased with our AHCCCS system. We feel it is a national model. I'll be prepared, after Mabel Chen's testimony, if you wish, to answer any questions.

[The prepared statement of Fife Symington follows:]

PREPARED STATEMENT OF HON. FIFE SYMINGTON, GOVERNOR, STATE OF ARIZONA

Mr. Chairman and Members of the Subcommittee. Arizona appreciates the opportunity to share with you our unique experience in providing health care to its Medicaid population. I will be giving an overview, and Dr. Mabel Chen, the Director of our Medicaid program, will offer more detail on some of the points I will make. Our program, the Arizona Health Care Cost Containment System, which we call AHCCCS, is a state conceived managed care program. As the Subcommittee considers Medicaid Block Grant proposals, AHCCCS should serve as a positive example of the kind of program states could implement if they were freed from the regulatory constraints of a traditional Title XIX program. In its thirteenth year of operation, AHCCCS provides health and long term care to Title XIX eligible individuals. AHCCCS operates under a Section 1115 federal waiver which provides the state relief from a number of federal requirements without which the system could not have been implemented nor could it continue.

AHCCCS also serves as an example of a high quality, cost-effective health care system that has garnered the support of Arizona citizens, providers, advocates, recipients, and taxpayers. AHCCCS is accepted in Arizona without controversy as the method for delivering health and long term care to the state's low income population.

Until October 1, 1982, Arizona was the only state in the nation without a Medicaid program. Prior to that time, health care for the indigent was provided and fully funded by Arizona's fifteen counties. In 1981, the State Legislature and the Governor recognized that the counties could not continue to pay the full cost for health care and began to explore various options which would, for the first time, bring federal Medicaid dollars to the state.

Central to these discussions was a determination by state leaders to create a managed care system which could deliver quality services, control costs, discourage the use of emergency rooms for primary care and avoid fraud and abuse practices which were reported in fee-for-service programs. In 1981, the legislature created AHCCCS as the first statewide Medicaid managed care system in the nation based on prepaid, capitated arrangements with Health Plans. In July 1982, HCFA approved the AHCCCS program as a three year research and demonstration waiver. The waiver has been continually renewed by HCFA since then, the most recent extension allowing AHCCCS to operate until October 1, 1997.

The Subcommittee should know that AHCCCS did not initially cover all Medicaid services. AHCCCS in its early years only focused on the provision of medical and acute care provided through prepaid, capitated Health Plans. Long term care was added in 1989 through the Arizona Long Term Care System after the medical program had stabilized. Modeled on a managed care approach, long term care is bundled with medical care services and is provided through prepaid, capitated Program Contractors. A phase-in of mental health services began in 1990 and will be completed on October 1st of this year.

It is important for the Subcommittee to understand that AHCCCS provides health and long term care services in a managed care framework to its entire Medicaid population:

- Children
- Pregnant women
- Children and adults with chronic illnesses and disabilities
- The elderly
- Families
- The medically indigent and medically needy (with 100% state funds)
- Individuals who are eligible for both Medicaid and Medicare
- The seriously mentally ill
- Physically and developmentally disabled persons

Managed care in Arizona is fully implemented in both rural and urban areas for Medicaid beneficiaries. AHCCCS does not achieve cost control through a limited

benefit package. Our Health Plans and Program Contractors provide the full Medicaid benefit package comparable to that of other states. Health Plans fully comply with EPSDT screening and follow-up treatment requirements. AHCCCS achieves cost control through its Health Plans and Program Contractors who receive a prepaid amount per member for each month the individual is enrolled, regardless of the services the member uses. In long term care this means Program Contractors receive the same amount whether an elderly person is served in his or her home or in a nursing facility. Most of our elderly and disabled prefer to receive care in their homes. Similarly, in the AHCCCS health care program, Health Plans receive the same monthly capitation amount whether a member is in the hospital or is treated in the physician's office. AHCCCS does have a reinsurance program for high cost cases which provides additional funds to a Health Plan once a specified threshold is met.

Today, AHCCCS is accepted as a cost-effective, innovative approach which provides access to mainstream health care. The Subcommittee does not have to rely on my observations or those of Dr. Chen since AHCCCS has been the subject of intense outside scrutiny. In fact, the federal government itself studied AHCCCS for the first eleven years of the program and came to the conclusion that AHCCCS saves money, provides greater access to care than traditional programs and, provides a higher quality of service. The managed care features of the program, coupled with market-based competition, have produced substantial cost savings for Arizona and federal taxpayers. When compared to a traditional Medicaid program, the AHCCCS health care program has saved 7% each year of its existence since 1982. When compared to a traditional Medicaid long term care program, the Arizona Long Term Care System has saved taxpayers 17% each year since 1990.

Increased competition among commercial and other organizations for the AHCCCS population continues to drive down capitation rates per person. This competition reflects the profitability of our Health Plans which is comparable to national averages for managed care organizations. In 1994, AHCCCS received an unprecedented 95 proposals from 21 different organizations to serve its members. As a result of this competition, capitation rates per person were reduced eight percent over the previous year. It is important to note that our hospital industry also remains financially strong in Arizona showing profitability above national trends. In part, this reflects that hospitals do well under the AHCCCS program.

However, the best measure of our success in providing access to health care is the satisfaction of our members found in several independent surveys. One study of AHCCCS members conducted by the Flinn Foundation in 1989 concluded "...the overwhelming majority of AHCCCS enrollees (95%) say they are completely satisfied with the program." A more recent Gallup poll confirmed these results finding 95% of AHCCCS members very or somewhat satisfied with their care. Another survey of our members sponsored by the federal government showed access to routine health care better under our program than a traditional fee-for-service program.

Managed care has been criticized by many for providing fewer services of a lower quality to Medicaid recipients. For AHCCCS this is not the case. In fact, a study sponsored by the federal government has shown that the overall intensity of services is the same for our program when compared to others. However, the services used by our members are less biased toward institutional care. Findings on quality are also inconsistent with the sometimes vocal critics of managed care. Pregnancy outcomes are comparable to other states and well-child care, including care for babies and immunizations, is more consistent with the standards established by the American Academy of Pediatrics.

Arizona's Health Plans and providers have formed a real partnership under the AHCCCS program. Fourteen Health Plans now participate and many more want to participate. Our Health Plans include an array of commercial, public and private organizations including Blue Cross of Arizona and CIGNA who recently became AHCCCS Health Plans. A substantial majority, eighty percent according to one estimate, of Arizona's physicians and other primary care providers also actively participate in the program. This is true mainstreaming. One of the cornerstones of AHCCCS is to provide each and every member with a primary care provider and to mainstream members into physician's offices. In marked contrast to some states, AHCCCS has the support of both its hospitals and its nursing facilities. AHCCCS can save money through the appropriate use of expensive services, not simply through cutting payments to providers.

We believe there is less recipient fraud and abuse under AHCCCS as well since each member must go through his or her primary care provider to access services. Our members cannot doctor shop to obtain multiple prescriptions for drugs. It is also far more difficult for members in our program to pass around their ID cards, since members are known by their primary care physician.

It would be natural for members of the Subcommittee to question why I support Block Grants since Arizona was able to achieve its success under current law albeit under a waiver. There are a series of important reasons for my support, beginning with AHCCCS itself. Although our program is in its thirteenth year of operation and has the authority to continue for two more years, AHCCCS is not permanent. In spite of its demonstrated success, under current law there is no vehicle to make AHCCCS a permanent program. A Block Grant strategy, with sufficient flexibility, will allow Arizona to achieve permanency. A Block Grant approach, again with adequate flexibility, will also allow AHCCCS to improve itself Most importantly, Arizona can move to streamline the complex Medicaid eligibility process and save substantial administrative dollars by replacing the myriad of existing eligibility groups with simple income based criteria.

My support for Medicaid Block Grants is also based on the flexibility it will provide Arizona and other states to take advantage of the local market and design creative state initiated solutions to problems:

- To customize their programs in line with local market realities rather than the one size fits all approach inherent in the Medicaid program today.
- To redirect administrative resources now devoted to federal regulatory requirements to monitor the system and outcomes of care and for new benefits or savings.
- To take further steps to eliminate the institutional bias of the Medicaid program by offering enhanced community based services in long term care and mental health programs.
- To free the state from Boren amendment requirements that tie payments to provider costs—this requirement impacts fee-for-service payments made by AHCCCS to providers, not payments made under managed care.

The Subcommittee should also understand that while some state creativity can occur under the waiver authority now provided through Section 1115 waivers this process is not a guarantee of innovation. The waiver process has been lengthy and protracted for some states although Arizona's experience has been more favorable. Under the current waiver process and without explicit authority, states may be prevented from taking actions or be asked to take actions they would otherwise not take.

Arizona is proud of the AHCCCS program. Our program took time and resources to build, something other states must recognize as they move to managed care. Congress also should be tolerant of and consider the transition time needed for states to develop cost-effective, high quality managed care as they design the Medicaid Block Grant strategy for the nation. I believe AHCCCS is a good model and provides one vision of what can be accomplished under a Medicaid Block Grant approach.

Mr. Chairman and members, I will be happy to respond to questions.

Mr. BILIRAKIS. Thank you very much, Governor. Dr. Chen.

STATEMENT OF MABEL CHEN

Ms. CHEN. Mr. Chairman and members of the subcommittee, I am pleased to be here to discuss changes in the Medicaid program.

As my Governor has mentioned, the AHCCCS program provides health care and long-term care to title 19 eligible individuals through a state-wide managed care system. Today, our health care program provides services to 430,000 people enrolled in 14 different health plans; 400,000 are eligible for Medicaid, 30,000 are eligible for the State funded health care program.

AHCCCS health plans are selected through a competitive bid process. Our selection criteria includes an evaluation of proposed capitation rates, the quality of each health plan operational and financial management, and the adequacy of the provider network set up by the health plan. Competition to serve AHCCCS members has increased substantially over time.

As my Governor indicated, because of increased competition, AHCCCS was able to reduce capitation rates paid to health plans by 8 percent in the last bidding cycle. This validates our assump-

tion that managed care savings are not just one-time savings which occur only at inception of the program.

Under the AHCCCS program, each individual's health care is managed by a primary care provider. This provider serves as both a gatekeeper for services and as the individual contact point for health care. The primary care provider is responsible for preventive health care, such as children's EPSDT screening and treatment, referral to specialty care, as well as in-patient hospital services.

One of the most unique features of AHCCCS is our long-term care program. In order to become eligible for the Arizona Long-Term Care Program, a person has to meet the financial requirements and medical requirements. The financial requirement in Arizona is equal to 300 percent of the SSI income standard. That means a person's income cannot exceed $1,374 per month.

Medical eligibility is determined through the pre-admissions screening process. Currently we have eight program contractors serving in the long-term care program, which includes five programs run by the county governments, one run by the State government agency, another two from the private organizations. There are 20,000 elderly, physically disabled and developmentally disabled who are receiving services in our long-term care program.

Program contractors receive a per-member per-month capitation payment to provide a full range of long-term care, medical care, and behavioral health services. Through our program, an individual can receive services provided in a nursing home, ICFMMR, or receive services in home and community services programs.

Program contractors receive the same capitation payment whether the individual is served at home or in a nursing facility. Because institutional care is much more costly, one capitation payment provides an incentive to serve people at home. As of today, 35 percent of the elderly, physically disabled and 95 percent of the developmentally disabled in our system are receiving services in the home and community services programs.

The program contractors provide each individual with a case manager and a member can choose a primary care provider to coordinate and oversee their medical needs. Evaluation of both the AHCCCS health care program and long-term care program have been very positive and show promising results, a measure of utilization, cost, quality and access to care. Two comprehensive studies of AHCCCS were conducted by Stanford Research Institute and Laguna Research on behalf of the Department of Health and Human Services. They have found overall intensity of services used was similar for Arizona's program compared with other States' Medicaid programs, but our program showed fewer in-patient hospital days and a greater number of member management and evaluation services, including routine office visits.

Mr. BILIRAKIS. Please summarize, Doctor, if you would.

Ms. CHEN. Thank you. And as far as cost savings, my Governor already mentioned that in 1993, the cost savings for acute care program is equal to $70 million and long-term care is equal to $80 million.

We are very proud of the finding on the quality of care provided in our system, as well as access to care. In addition to the research findings, our members have a very high level of satisfaction for the

care they receive in the system. Recently, we contracted with our university research lab to conduct a member survey on pregnant women and 90 percent of the pregnant women receiving care were very satisfied with the care provided in the AHCCCS system.

If you believe, as we do, that the AHCCCS program is a successful model for delivering high quality care at an affordable cost, the States should be given the flexibility to implement such programs without going through a lengthy waiver process.

I would like to provide you with a few examples of the problems in the current law that we find.

Mr. BILIRAKIS. I wonder if you couldn't retain those and possibly bring them up during questioning, Doctor.

Ms. CHEN. Okay.

Mr. BILIRAKIS. Thank you so much.

Ms. CHEN. Okay. Thanks.

Mr. BILIRAKIS. Let's move on then at this point. Unless you have a very short summarized statement.

Ms. CHEN. I just wanted to share some of the lessons we have learned in implementing the AHCCCS program.

Mr. BILIRAKIS. I would rather you didn't do that now during your opening statement, though, because we'd run out of time.

Ms. CHEN. Okay.

Mr. BILIRAKIS. You'll have an opportunity to do it.

Ms. CHEN. Thank you.

[The prepared statement of Mabel Chen follows:]

PREPARED STATEMENT OF MABEL CHEN, M.D., DIRECTOR, ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

Mr. Chairman and Members of the Subcommittee. I am pleased to be here today to build on Governor Symington's introduction of the Arizona Health Care Cost Containment System. As he mentioned, AHCCCS provides health and long term care to Title XIX eligible individuals through a statewide managed care system which operates under a Section 1115 waiver granted by the Health Care Financing Administration. AHCCCS is a system which works. It works for providers, members and the community.

Today, the health care program provides services to 430,900 persons enrolled in 14 Health Plans: 398,000 who are eligible for Medicaid and 32,900 who qualify for state-funded services. AHCCCS Health Plans are selected through a competitive bid process which evaluates not only the price of services, but the adequacy of each Health Plan's operational and financed management. Critical to the selection process is an evaluation of the adequacy of the proposed Health Plan provider network. Competition to serve AHCCCS members has increased substantially over time—21 different organizations sought the AHCCCS line of business in our last procurement. As the Governor indicated, because of increased competition, AHCCCS was able to reduce capitation rates paid to Health Plans by eight percent in our most recent competitive cycle. This validates our assumption that managed care savings are not just one-time savings which occur only at the inception of a program. The selected Health Plans provide health care to mothers and children, the elderly who do not need long term care, disabled children and adults, children in foster care, families, and the state-funded medically needy and medically indigent. The program also serves a number of individuals who are eligible for Medicaid and Medicare. While many state managed care initiatives have targeted the AFDC population, AHCCCS has successfully served the entire Medicaid population through its Health Plans.

Under the AHCCCS program, each individual's health care is managed by a primary care provider. This provider serves as both a gatekeeper for services and as the individual's contact point for health care. The primary care provider is responsible for preventive care such as childrens' EPSDT screenings and treatment, referral to specialty care as well as inpatient hospital services. Because a primary care provider is monitoring each members' health care, fraud and abuse resulting from "doctor shopping" found in traditional Medicaid programs is significantly curtailed.

On of the most unique features of AHCCCS is the Arizona Long Term Care System (ALTCS) which is Arizona's statewide managed long turn care system. Under ALTCS, Program Contractors receive a per member, per month capitation payment to provide a full range of long term care, medical care and behavioral health services to the elderly, physically disabled and developmentally disabled individuals who are determined by AHCCCS to need long term care. Through ALTCS, individuals can receive home and community-based services or services in a nursing facility or Intermediate Care Facility for the Mentally Retarded if the member is developmentally disabled. Program Contractors receive the same capitation payment whether the individual is served at home or in the nursing facility. Because institutional care is much more costly, capitation provides an incentive to serve the individual in their home—which is also the preference of most elderly, physically and developmentally disabled people. In contrast to findings elsewhere in the country, HCFA sponsored research has shown that Arizona's home and community based program is actually supplanting nursing facility care.

Once an individual is determined to need long term care services through a preadmission screening process and is determined financially eligible for Medicaid, an individual is enrolled with the Program Contractor in their geographic area. That Program Contractor provides each individual with a case manager and the member selects a primary care practitioner to coordinate and oversee the person's needs. Program Contractors serve approximately 20,000 elderly, developmentally disabled and physically disabled people and include private Health Plans, counties and the Arizona Department of Economic Security for persons with developmental disabilities.

Evauations of both the AHCCCS health and long term care programs have been positive and show promising results on measures of utilization, cost, quality, and access to care. Two comprehensive studies of AHCCCS were conducted by SRI and Laguna Research on behalf of the federal government. Laguna and SRI found:

- While the overall intensity of service use was similar for Arizona's members for both health and long term care, the pattern of use was quite different. AHCCCS and ALTCS showed fewer inpatient hospital days, fewer procedures, and a greater number of member management and evaluation services, including routine office visits. For ALTCS, Laguna found evidence of a more coordinated system of care which provided more opportunities for the elderly and disabled to transition from home care to nursing facility care or from nursing facilities to a home setting.
- With respect to cost, as Governor Symington reviewed, AHCCCS health care programs averaged savings of 7% per year for the first 11 years of the program. Long term care cost savings were estimated at 17% per year, excluding the initial year of operation.
- AHCCCS is most proud of the findings on the quality of services provided. Well child care, including care for babies and immunizations under AHCCCS, were found to be in greater conformity with the American Academy of Pediatrics guidelines than traditional fee-for-service programs. Further, pregnancy outcomes were the same, although AHCCCS showed a smaller number of prenatal visits.
- Findings on access to services is also favorable. Access to routine care was found to be better under the AHCCCS program and a significantly greater number of members report that they have a place for care on evenings and weekends in contrast to a traditional program.

Research findings, however, are not important if AHCCCS members are not satisfied with the care they receive. The Governor's testimony highlights the high satisfaction levels of AHCCCS members with their care as reported in a number of independent studies. I would add only the findings of the recent study conducted by the Arizona State University Survey Lab of women covered by AHCCCS who recently gave birth. The results indicate that 90 percent of women receiving prenatal care were "satisfied" to "very satisfied" with their care.

If you believe, as we do, that the AHCCCS program is a sensible model for delivering high quality' affordable health care to low income populations, then states should be given the flexibility to implement such programs without going through the hurdle of the federal waiver process. Congress is now considering a Block Grant to alleviate these hurdles. While I believe that a Block Grant is best accomplished by starting fresh with an entirely new statute to replace Title XIX, it is important to the debate to understand the limitations of current law to innovative managed care programs and to innovation in general.

Let me provide a few examples of the problems in current law for AHCCCS that only can be overcome with an 1115 waiver.

- AHCCCS could not ask its members to select a Health Plan once a year as most of us do for our own health care coverage.
- By law, only 75% of AHCCCS Health Plan membership could be Medicare or Medicaid eligible individuals. While this requirement is problematic for health care services, it is even more difficult in a long term care system since there is little, if any, private sector managed care enrollment. Further, Medicaid, not the private sector, pays for the majority of long term care services. The requirement is also a problem for innovative programs for persons who are dually eligible for Medicare and Medicaid. AHCCCS has found that some Medicare HMOs are reluctant to serve the Medicaid population for fear that they will exceed the 50% Medicare composition requirement. Although this rule was designed to serve as a proxy for quality, commercial and governmental managed care programs today have much more well-defined measures of quality of care. For example, AHCCCS is now developing a quality outcome system which tracks care against established standards. Our Health Plans have also independently sought accreditation from the National Committee for Quality Assurance, a large accrediting body for managed care organizations.
- Under existing freedom of choice provisions, AHCCCS would be required to operate a parallel fee-for-service system and provide members the opportunity to receive their services fee-for-service—an approach which would compromise the managed care benefits of our system. The Subcommittee should be aware that AHCCCS does provide our Medicaid members with a choice of both a Health Plan and a primary care provider. In Maricopa County (Phoenix), members have a choice of nine Health Plans; in Pima County (Tucson), members can choose from among five Health Plans. In the remaining counties, members have at least two choices of Health Plans. Members also have a broad choice of physicians and other primary care providers since 70% to 80% of Arizona providers actively participate in AHCCCS through one or more Health Plans.

In addition to the limits placed on innovative managed care programs under current law, there are also limits on innovation in areas of eligibility, provider reimbursement and services. For example:

- Without a waiver, states cannot simplify current Medicaid eligibility rules and adopt a single, income standard. States must also provide three months of retroactive coverage to those found eligible making it impossible to manage care.
- States cannot pay the best market rate for institutional services because of the various courts' interpretation of the Boren Amendment.
- Even with a waiver, states cannot adopt a commercial benefit package for members because of mandatory benefit requirements and restrictions on copayments—even for nonemergency use of emergency services.

While a number of states have recently taken advantage of Section 1115 federal waiver authority to implement managed care and eligibility changes, there is no guarantee that the waiver will be approved even after lengthy negotiations.

We believe that Arizona's experience suggests that states can and should be given programmatic flexibility. Given Arizona's experience and status, we have serious technical concerns with the method for distribution of funds under a block grant proposal. We are primarily concerned about a proposal that locks in a base year and imposes uniform spending limits on the states. We are concerned because:

- Arizona is a low cost Medicaid state, among the ten lowest cost states in spending per beneficiary.
- In as much as Arizona already has a managed care program, we can not look to the kinds of savings that can be realized when a fee-for-service state shifts to managed care.
- Not all of Arizona's Medicaid benefits are phased-in at this time (e.g. mental health). Therefore, these costs are not in any base year which could be used for this purpose.
- Our long term care program is not fully stabilized and continues to show the faster growth seen for most new programs.
- Arizona is a low disproportionate share state.
- Arizona's population is growing. The Census Bureau estimates that Arizona's population will grow at twice the national average over the next ten years.
- Arizona is a border state. Given that there is considerable uncertainty around Mexico and the federal requirements for providing health care to undocumented persons, this creates uncertainty for our program.
- Arizona has modest eligibility criteria today when compared with some states.

If the distribution formula establishes a base year and limits growth, Arizona will be penalized for its past success in controlling cost and also for a growing popu-

lation. It is only reasonable that the distribution of funds under a Medicaid Block Grant consider these elements.

AHCCCS has learned a number of lessons which are relevant to states who will soon move to managed care, perhaps even more quickly under a block grant than under current law:

- Health Plans, Program Contractors, and providers are partners, not adversaries, in any managed care effort. The Health Plans and Program Contractors are instrumental in building the network of providers needed to mainstream recipients into private physician offices and home and community-based care.
- Enrollment processes and automated systems must be developed and in place to ensure that members can be properly enrolled in the Health Plan of their choice. Automated systems allow Health Plans to provide critical information on the quality and extent of the services members receive.
- While Arizona did not have a traditional Medicaid program when our managed care program began in 1982, other states who choose to convert to managed care must allow time for a transition period. These states must dedicate the resources to operate two programs during the transition period: the new managed care program and the existing fee-for-service program.
- Operational, financial and quality monitoring systems must be in place to ensure that problems are identified early and corrective action can take place.

Mr. Chairman, members, if you have any questions, I would be pleased to answer them.

Mr. BILIRAKIS. Let's go on to Secretary James.

STATEMENT OF KAY COLES JAMES

Ms. JAMES. Thank you, Mr. Chairman and members of the committee, for this opportunity to provide Virginia's perspective on the exciting opportunities we have to transform the Medicaid program.

As the Secretary of Health and Human Resources for Governor George Allen and the Commonwealth of Virginia, let me assure you that Virginia welcomes the freedom a block grant would offer and we are prepared to administer our own program under a block grant to take care of the health care needs of Virginia's poor, elderly and disabled.

Our desire for the Virginia Medicaid system is reformation that preserves quality care in appropriate settings within finite fiscal resources. You have heard from several Governors in previous panels about the escalating costs of their States' Medicaid program and their concerns about the impacts that this will have upon their very solvency. I cannot echo this sentiment strongly enough. In the States, the tough choices and decisions we make today will make or break our State budget.

In Virginia, over the past 10 years, Medicaid expenditures have more than doubled and now stand at almost $1 billion in State funds, matched by $1 billion in Federal funds. In 1991, growth in the medical budget was 30 percent. This moderated to 11.4 percent in 1995 and in 1996, the growth is projected to be 2.1 percent. This demonstrates our ability to contain costs.

For example, Virginia has implemented numerous cost saving initiatives, such as managed care, better management of hospital stays and emergency room visits, and improved recoveries of pharmacy rebates. However, trends such as the growth of the elderly population and expanding Federal mandates make limiting growth in the Medicaid program almost impossible to sustain.

States and the Federal Government cannot support this growth in entitlement programs at the present tax rate without borrowing heavily against our children's future. The tremendous costs already associated with the long-term care component of Medicaid are just

a preview of the burden to come. Even if States curb medical inflation in their programs, the increasing numbers of elderly and disabled persons eligible for Medicaid services will increase beyond our State's ability to pay.

As the baby boomer generation ages and the demand for long-term care assistance grows, Medicaid spending will grow from its current uncontrollable level to an unsustainable one. States need the flexibility and authority now to prepare for the demands that will be placed on Medicaid in the very near future. States need relief from Federal oversight. Specifically, they need relief from Federal mandates.

In every program Virginia administers, Governor Allen has charged us to both provide the finest quality service possible in the most fiscally prudent fashion. In developing budgets for our agencies, we believe that policy and not numbers drive budgetary decisions. The medical care that we provide to Virginia's poor, disabled and elderly is no exception.

I have been concerned that the debate over transforming the Medicaid system has occurred in a vacuum, however, ignoring other important elements of the spectrum of services that States provide. Critics of reform seem to assume that the only way to reduce the number of Medicaid beneficiaries and the cost is to cut services and eligibility. However, as someone who manages Medicaid, as well as social services, job training and public health, I assert that the prospect of block grants in all of these areas offers us the first opportunity in decades to create a true safety net of services to those in need.

In transforming the Medicaid system, we must consider the following priorities; preventing illness through health promotion and disease prevention; educating our consumers about appropriate treatment and care; encouraging providers to furnish and disseminate information about costs and quality of care to consumers; preventing fraud and eliminating loopholes; moving welfare recipients into self-sufficiency so that they no longer need Medicaid; and, developing insurance alternatives and promoting planning for long-term care.

Even within the confines of existing Federal mandates and the tedious waiver process, we have implemented and are expanding Medicaid managed care initiatives which are improving access and quality while simultaneously containing costs. Since January of this year, almost 74,000 Medicaid recipients in Virginia have voluntarily chosen to enroll in HMO's over the traditional fee-for-service Medicaid program.

As long as managed care assures the highest possible care for our citizens, we will continue to offer this choice to our recipients. One example of how well HMO's in Virginia are meeting recipients' health care needs is regularly found in the area of prenatal care.

Mr. Chairman, I will summarize at this point and will save the rest of my comments for the question and answer period. I just want to make the point that in Virginia, through a series of innovations, we have managed to do what some say is near impossible to do. We have contained costs. We have provided quality care for those in need in the Commonwealth of Virginia and are looking toward the future and looking at programs, like how to provide long-

term care services, which is the most rapidly expanding area. We know that it can be done and are pleased to be here to share that information with you today.

[The prepared statement of Kay Coles James follows:]

PREPARED STATEMENT OF KAY COLES JAMES, SECRETARY OF HEALTH AND HUMAN RESOURCES, COMMONWEALTH OF VIRGINIA

Thank you, Mr. Chairman and members of the Committee, for this opportunity to provide Virginia's perspective on the exciting opportunities we have to transform the Medicaid program.

As Secretary of Health and Human Resources for Governor George Allen in the Commonwealth of Virginia, let me assure you that Virginia welcomes the freedom a block grant would offer. We are prepared to administer our own program under a block grant to take care of the health care needs of Virginia's poor, elderly, and disabled.

States do not need constant intervention and oversight by the federal government to act responsibly and take care of our own citizens. Arguably, our record on compassion, cost containment, and innovation has been much better than the federal government's. States that have led and are continuing to lead the way in transforming welfare, for example. In fact, Virginia received the most recent federal waiver and, on July 1, began implementing the most comprehensive, compassionate and forward-looking program in the country. Designed with the input of welfare recipients themselves and praised by the President, Virginia's program moves beyond the rhetoric of empowerment to reality by promoting work, family, personal responsibility, and individual self-reliance.

As to fiscal responsibility, Virginia, like many other states, has been balancing its budget for years. We have to—under the Virginia Constitution, spending in the budget cannot exceed revenues. It takes resolve and discipline to balance a budget. You have to set priorities, and you have to say "no" to special interests. Not only are the States closer to the people and more responsive, we have experience on our side.

Medicaid In Virginia: Costs Rising at 15-20 Percent Per Year

My desire for the Virginia medicaid system is reformation that preserves quality care in appropriate settings within finite fiscal resources. You have heard from several governors about the escalating costs of their states' Medicaid program and their concerns about the impact that this will have upon their very solvency. I cannot echo this sentiment strongly enough—in the states, the tough choices and decisions we make today will make or break our state budget. In Virginia, over the past ten years, Medicaid expenditures have more than doubled and now stand at almost a billion dollars in state funds matched by a billion dollars in federal funds. In 1991, growth in the Medicaid medical budget was 30 percent. This has moderated to 11.4 percent in 1995 and in 1996 the growth is projected to be 2.1 percent.

This demonstrates our ability to contain costs. For example, Virginia has implemented numerous cost-saving initiatives such as managed care, better management of hospital stays and emergency room visits, and improved recovery of pharmacy rebates.

However, trends such as the growth of the elderly population and expanding federal mandates make limiting growth in the Medicaid program impossible to sustain. States and the federal government cannot support this growth in entitlement programs at the present tax rate without borrowing heavily against our children's future. The tremendous costs already associated with the long-term care component of Medicaid are just a preview of the burden to come. Even if states curb medical inflation in their programs, the increasing numbers of elderly and disabled persons eligible for Medicaid services will increase beyond a state's ability to pay. As the Baby Boom generation ages and the demand for long-term care assistance grows, Medicaid spending will grow from its current uncontrollable level to an unsustainable one. States need flexibility and authority now to prepare for the demands that will be placed on Medicaid in the very near future. States need relief from federal oversight, specifically, they need relief from federal mandates.

Federal Mandates

Part of the reason for the substantial increases in Medicaid cost has been the Congressional mandates from 1988 through 1990 to expand the Medicaid program and eligible populations. Federal statutes require the Commonwealth to pay half the cost of mandated medical expenses in which the Commonwealth had little or no choice in the matter. For example, the Boren Amendment and Early Periodic

Screening Diagnosis, and Treatment (EPSDT) have greatly expanded State Medicaid financial exposure to providers and beneficiaries without regard to the State Plan. The Boren Amendment is a provision of Medicaid law that was intended to provide a ceiling for provider rates by requiring Medicaid to pay medical facilities rates that are reasonable and adequate to meet the cost that must be incurred by efficiently and economically operated facilities. The Boren Amendment was originally written to provide a limit on Medicaid spending for medical hospital services, but it has been interpreted by the Courts to be a mandatory floor and has spawned litigation throughout the country. The Boren Amendment may be the federal mandate that, more than any other, would limit a state's ability to live within a federal cap on expenditures, since it affects over half of Medicaid's expenditures. This amendment should be replaced with language that explicitly provides states the ability to use free market forces to drive down the prices charged to Medicaid as a purchaser to health care.

In many cases, the federal mandates for the EPSDT program have greatly expanded State Medicaid expenditures for services beyond those provided to children covered by private commercial insurance. EPSDT requires states to cover treatment services for physical and mental illnesses outside the state's covered services for anyone under age 21 and has inhibited states from establishing appropriate service limits for this population. In other words, this program prevents us from bringing the services to this Medicaid population in line with those of the taxpaying families.

Block Grant Flexibility

In every program Virginia administers, Governor Allen has charged us to both provide the finest quality service possible in the most fiscally prudent fashion. In developing budgets for our agencies, we believe that policy and not numbers drives budgetary decisions. The medical care that we provide to Virginia's poor, disabled, and elderly is no exception. I have been concerned that the debate over transforming the Medicaid system has occurred in a vacuum—ignoring other important elements of the spectrum of services that states provide. Critics of reform seem to assume that the only way to reduce the number of Medicaid beneficiaries and the costs is to cut services and eligibility. However, as someone who manages Medicaid as well as social services, job training and public health, I assert that the prospect of block grants in all of these areas offers us the first opportunity in decades to create a true safety net of services to those in need. In transforming the Medicaid system, we must consider the following priorities:

- Preventing illness through health promotion and disease prevention;
- Educating our consumers about appropriate treatment and care;
- Encouraging providers to furnish and disseminate information about costs and quality of care to consumers;
- Preventing fraud and eliminating loopholes;
- Moving welfare recipients into self-sufficiency so that they no longer need Medicaid; and,
- Developing insurance alternatives and promoting planning for long-term care.

Medicaid Managed Care

Even within the confines of existing federal mandates and the tedious waiver process, we have implemented and are expanding Medicaid managed care initiatives which are improving access and quality and while simultaneously containing costs. Since January of this year, almost 70,000 Medicaid recipients in Virginia have voluntarily chosen to enroll in HMOs over the traditional fee-for-service Medicaid program. As long as managed care assures the highest possible care for our citizens, we will continue to offer this choice to our recipients.

One example of how well HMOs in Virginia are meeting recipient's health care needs is regularly found in the area of prenatal care. In one instance, a skilled nurse from her HMO regularly visited and counseled with a pregnant woman in the Virginia Tidewater area. As a result, the woman developed better mothering skills and created a better home environment, and the newborn child had a higher than average birth weight. This is a wonderful example of how in a managed care system, the pregnant woman's care focused on her individual needs.

The rapid rise in HMO enrollment in Virginia shows how Medicaid recipients want to move into the mainstream health care system. We can take this success further, by removing the federal mandates and granting states flexibility so Medicaid can operate more like a private insurer and expand managed care statewide. From Virginia's perspective, the federal government is a source of federal rules and mandates that require states to cover specific populations and benefits and constrain state flexibility in setting provider payment rates and in adopting broad scale cost-containment measures that preserve quality of care, such as managed care. One of

our goals for Medicaid reform would be similar to welfare reform, to empower individuals to take personal responsibility for their health care.

Medicaid Long-Term Care Initiatives

Medicaid, a program originally conceived to provide a safety net for poor women and children, is now the biggest long-term care insurer for the elderly in the country. Nursing home costs paid by Medicaid are the fastest growing expense in the Commonwealth and have doubled since 1988. Virginia pays nearly half of its Medicaid budget for nursing home/long-term care and ancillary medical services for the elderly despite the fact the elderly constitute only a small fraction of the Medicaid recipients. Part of the reason for the substantial increase in nursing home costs is the Medicare Catastrophic Coverage Act which allows asset and income transfers for nursing home residents. This has cost Virginia $19.3 million in FY 1992. This Act and loopholes in the Medicaid laws have encouraged a phenomena of perverse incentives for financially independent elderly to impoverish themselves. As a result, Medicaid is providing benefits for the middle class who have given their resources away to become eligible for welfare benefits. Rather than encourage people to save for retirement and disability, federal statutes have the unintended result of encouraging people to spend and give away their assets to be eligible for welfare. For example, in a recent case in Chesterfield County, a circuit court ordered a husband in a nursing home to transfer up to $590,400 to his wife so that he might become eligible for Medicaid.

I can think of few other examples where government policies have contributed so negatively to the attitude and actions of our citizens. Government policy has encouraged many to abandon a lifetime of responsible behavior in exchange for the promise of complete care. While it may be legal and acceptable to spend down and dissolve our assets, this practice is bankrupting our system and denying services to the truly needy.

To control the escalating long-term care costs, we are implementing managed care programs for the elderly and disabled. Effective July 1, 1995, we have expanded our MEDALLION program to the non-institutionalized aged, blind, and disabled population. In the fall, we will be piloting the PACE program. This Program for All-inclusive Care for the Elderly will replicate a unique model of managed-care service delivery for approximately 3,000 very frail elderly living in the community who are eligible for nursing home placement. The model of care will include adult day health care and other multi-disciplinary case management to provide services so the elderly can remain safely independent in their homes rather than be institutionalized in a nursing home at taxpayers' expense.

Conclusion

Our goal then in transforming the Medicaid system, as in the overall health care reform debate, is to improve access to affordable and appropriate quality care. Cost containment and improving quality of services are not mutually exclusive.

I would be remiss if I did not emphasize again that the most important person in the transformation of Medicaid are the recipients who receive services paid for by Medicaid dollars. We want to empower them to make informed decisions and to encourage their self-sufficiency and health conscious behaviors in a quality care environment at reasonable cost.

Thank you for the opportunity to testify here today. I welcome your questions.

Mr. BILIRAKIS. Thank you so very much, Secretary James. Mr. Condon.

STATEMENT OF CHARLES MOLONY CONDON

Mr. CONDON. Thank you, Mr. Chairman. It's good to be with you from South Carolina.

As I understand what you're looking at, you're looking at trying to give the States flexibility to reduce Medicaid costs, as well as to accomplish the goal, which is to increase good health in America. I've got a story to tell you that—I wish it were a story, but it's true. It's under the heading of "no good deed goes unpunished," I believe, in this country.

By way of background, I was recently elected in the last general election as the Attorney General, but before that I was the Circuit Solicitor, a District Attorney along the coast of South Carolina, in

the counties of Charleston and Berkeley, and I was the District Attorney there or Circuit Solicitor for over a decade.

In about 1989—I remember the date because it was before this Hurricane Hugo came ashore in Charleston County—I was contacted by the Medical University of South Carolina, which was unusual contact to me, because they were concerned about the ever-rising numbers of cocaine babies they were seeing in the hospital there.

What we did is we developed a program, in my view, that greatly reduced the numbers of cocaine babies very effectively, and let me talk about that. Specifically, we targeted the use of crack cocaine during pregnancy. As I'm sure you know, cocaine use by expectant mothers is a really, really serious problem in this country. As a matter of fact, 1 out of every 10 babies born in America today is exposed to cocaine in the womb—1 out of every 10.

So what we did is I invited everybody involved with the problem to come talk about it. We had the police chief, Chief Ruben Greenberg of Charleston come. We had the people from the child care advocacy centers to come, and we had people from the treatment facilities. And here's what they told us. We know you've got this program in place already at the hospital here where you educate the women about the dangers of cocaine. You offer them free drug treatment.

They asked us a question, how many people went, and the authorities there were quick to say, well, only one has gone so far in the last year or so. And what's happened with your cocaine babies? Well, we started out having 4 or 5 people come into the hospital each month testing positive for cocaine. Now it's up to 20 to 30 a month. I don't know if you've ever had the occasion to see cocaine babies. I have. To me, it's one of the things that, in this democracy, shouldn't happen because it's entirely preventable.

We use the word tragedy too often, I think, in our discourse. This isn't a tragedy because it's not something we can't control. It's not like birth defects. It's an atrocity and people are intentionally taking the cocaine and the crack cocaine, the possession of which in my State is a felony. Possession of crack cocaine is a felony under South Carolina law.

So everyone got together and the strongest advocates for doing something from a coercive standpoint were the people who treated drugs directly. They said the reason they don't go is because there's no sanction in place. So we all got together, everyone agreed to this, that we would have a policy whereby if someone came into the hospital and they tested positive for crack cocaine or cocaine, they would have to go to drug treatment, free drug treatment or they would be arrested. There would be a sanction in place.

And what happened? Here's what happened. Without any decrease in the numbers of prenatal visits or any decrease in the numbers of in-hospital births, the numbers of people testing positive for crack cocaine or cocaine decreased by 75 percent.

I was the District Attorney there and I wasn't looking for extra work and I routinely would ask the hospital authorities and the doctors is this working. It didn't cost any money, mind you. This was a totally innovative program. And the greatest advocates of the program besides the people who treated the drug addicts were the

doctors, who don't tend to be, I think, a liberal group. They tend to be conservative at times, but they also tend to be one concerned primarily about the children.

It's working. We need your help here. Please keep involved. We kept monitoring this month by month and what would happen is the same thing; the numbers of cocaine babies were down and hospital visits were the same and the numbers of people testing positive for crack cocaine went down to about 4 or 5 a month. It seemed to be working beautifully.

Here's what happened. Again, this goes under the topic "no good deed goes unpunished." The ACLU got wind of this project, this program, and filed lawsuits against all of us personally, asking for $3 million or $4 million in personal damages. There was no injunction granted in Federal Court. The program continued. At Health and Human Services, we had a hoard of bureaucrats come into Charleston County and they were concerned about the program. We said fine, look into it, investigate it. Then the day came, and this is what they said in a written letter to us, "If you don't stop this program immediately, we will withdraw all Federal funding from your hospital." We'll close down the cancer center, the children's center. They had their golden rule—we have the gold and we set the rules.

Our head of the hospital, Dr. Edwards, former Governor of South Carolina and who was the Energy Secretary under President Reagan, capitulated, as he had no choice. But I urge you, when you look at this problem and you look at what I think should happen in this country in terms of our federalism and our democracy, we out at the States have a mind, we have a brain, we can address these problems.

I know you can do a lot from Washington, but if you think you can micromanage the entire country with rules for every locality, it won't work. And I have yet to this day had anyone explain to me why we shouldn't, in Charleston, South Carolina, have been able to continue this program, because it saved money, but much more importantly, it saved babies.

Thank you.

[The prepared statement of Charles Molony Condon follows:]

PREPARED STATEMENT OF CHARLES MOLONY CONDON, ATTORNEY GENERAL, STATE OF SOUTH CAROLINA

Mr. Chairman, ladies and gentlemen, my name in Charlie Condon. I am Attorney General for the State of South Carolina. I sincerely appreciate this opportunity to be heard today on the issue of the transformation of the Medicaid program and its impact on the states.

A central issue in this debate in whether the Medicaid block grant program ought to be significantly modified to give the individual states the flexibility we need to make better use of increasingly limited federal resources. In my judgement; the states are indeed able to develop innovative and cost-effective programs if we are given an opportunity to so go.

Today, I would like to offer you a dramatic example of an innovative program we developed a few years ago in South Carolina. In offering this testimony, it may be helpful for me to give you a brief summary of my personal background.

I was elected to the office of Attorney General for the State of South Carolina in the 1994 general election. Prior to that, I served for over a decade as District Attorney in my state's Ninth Judicial Circuit. During my term as District Attorney, I worked with the local police and the Medical University of South Carolina in developing a new interagency program on illegal substance abuse, a program we announced in 1989.

Specifically, our program targeted the use of crack cocaine by women during pregnancy. As I'm sure you know, cocaine use by expectant mothers in a growing problem that poses a very serious health rink for both the mother and the child. In neonatal hospitals all across our nation, you can see devastating examples of this problem. And believe me, it will break your heart to see newborn babies shaking and crying uncontrollably. If indeed they survive at all, these babies are born sharing their mother's addiction to crack cocaine.

And this in a very widespread problem. *One out of every ten babies born in America today in exposed to cocaine in the womb.* Many of these children die. And those who do survive are far more likely than other infants to be afflicted by serious behavioral problems, birth defects, and various learning disabilities.

Certainly the cruel suffering that these cocaine babies endure is the greatest cause for concern. But we should also be mindful of the reality that the cost of delivery and care in astronomical. A normal delivery of a healthy child can cost as little as five hundred dollars.

By comparison; delivery of a "crack baby" can cost as much an $750,000 or more. And many if not most of these damaged babies are born to welfare mothers. So it is primarily the taxpayers of America who pick up the bill through MEDICAID or through other public funding of hospitals. Also, according to the General Accounting Office one single cocaine baby can run up a lifetime cost of one million dollars in special medical and educational needs. We are therefore talking about a very serious problem financially as well as in terms of sheer human misery.

My involvement with the problem of cocaine babies began when a neonatal nurse at the Medical University of South Carolina and other Medical University representatives apprised me of the seriousness of the problem.

Nurse Shirley Brown and others informed me that an average of 24 pregnant mothers entering the hospital each month tested positive for crack cocaine. In each case, MUSC staff members made a desperate effort to educate the women involved on the terrible damage they were doing to themselves and to their unborn babies. And yet virtually none of the women were willing to enter *free* drug treatment programs that were readily available to them.

To discuss the problem, we met with the Police Chief of Charleston, South Carolina, Reuben Greenberg, an well as numerous drug rehabilitation experts. The experts told us that if we really wanted to get the women into treatments there would have to be a mandatory element—a force that compelled them to enter treatment programs they would never voluntarily seek. To provide that encouragement we launched a treatment-based amnesty program for pregnant mothers who tested positive for crack cocaine use.

Here in how the program worked:

The mothers were given a simple choice. They either had to enter treatment immediately or face prosecution. If they agreed to participate in a drug rehabilitation program, we offered them immunity from prosecution. We only asked them to enter the program and stop abusing their unborn children with illegal drugs.

The results of the program were immediate and very dramatic. Soon after we launched the program, the number of women who tested positive for cocaine decreased by 75%. Every woman who entered the program signed a consent form to be tested. No one was denied rights or due process.

At this point I should emphasize that there was no decrease in the number of prenatal visits or in the number of live births at the hospital. Let me repeat that for emphasis. The number of prenatal visits and live births stayed the same. Expectant mothers were not going elsewhere. They were simply not taking drugs to avoid possible prosecution. In other words, the program was working. Other states were looking at our program as a model. But then, the forces of opposition began to organize.

First a lawsuit was filed in federal court by a group called the Center for Reproductive Law and Policy, an off-shoot of the American Civil Liberties Union. Then federal investigations were begun by the National Institutes of Health and by the Department of Health and Human Services. Legally, we were on very strong ground.

The Medical University was fully prepared to defend the program and fight the allegations in court. The facts and the law were both on our side. But then, the United States Department of Health and Human Services threatened to withdraw federal funding from the hospital. They exercised the federal version of the Golden Rule: They had the gold. So they made the rules.

As incredible as it sounds, the federal government was willing to shut down the entire Medical University of South Carolina, the cancer center, the Children's Hospital and to discontinue medical services to an entire region of South Carolina to stop one small program that the bureaucrats in Washington felt to be politically incorrect.

Of course, the Medical University had no choice in the matter. They were and are heavily dependent on federal funding. So the program was dropped. And that was tragic indeed. Now once again the babies are dying. And there in nothing we can do. And that in why I am here today, to urge you to give the states the flexibility we need to do a better job.

The program we launched in Charleston, South Carolina was making a real difference. Had we been given a chance, we could have proven our case in court. We could have expanded our local program. And today, we could be saving hundreds of lives and millions of tax dollars every year in South Carolina. But the Department of Health and Human Services wouldn't even let us try.

Now the time has come to change the operational philosophy of the government in Washington. And I believe we are in the process of doing just that. Recently, the National Association of Attorneys General asked me to chair a Tenth Amendment Working Group. We are now working on a report for Attorney General Janet Reno to express our view that a greater emphasis must be placed on protecting and expanding the authorities of the states.

In our time, we still have a great deal to learn from the Frenchman, Alexix de Toqueville, who captured in words the unique magic of America when he said that our strength does not come from the central government. The real strength of America is in its local governments. The more power we give to citizens at the state and local level, the more they will trust and support their government.

Looking back on our cocaine baby program in South Carolina, even today, the citizens of South Carolina cannot begin to understand why a program that was working so well had to shut down so abruptly. And frankly, I don't understand it either. I hope this Subcommittee and the Congress will help us strengthen the role of the states. I urge you to give us the flexibility we need to make democracy work efficiently for all the citizens of America.

Thank you.

Mr. BILIRAKIS. Thank you, sir. Thank you very much. Mr. Vladeck.

STATEMENT OF BRUCE C. VLADECK

Mr. VLADECK. Thank you very much, Mr. Chairman. It's good to be back here today. Let me very briefly comment on three of the issues relative to this hearing.

One, I will talk about the degree of flexibility that exists in the Medicaid program under current law. Let me elaborate a little bit on that by making some references to some personal experiences of my own, and then briefly discuss some of the proposals for change in the Medicaid program.

As all of you on the committee know, Medicaid serves a broad population of Americans and covers a wide variety of services. As you also know, and reference has been made to it already this morning, roughly 70 percent of the persons covered by the Medicaid program are low income women and children. Indeed, about 70 percent—almost 75 percent of Medicaid expenses are on behalf of the elderly and disabled.

What needs to be emphasized in that regard is every State has its own system under existing Medicaid law for responding to the needs of the elderly and disabled. The proportion of elderly persons receiving community-based long-term care services, for example, ranges from approximately 50 percent in the State of Oregon and 1 or 2 other States who have been in the lead in this regard to zero in a number of other States that have not chosen to undertake home and community-based services.

In fact, to talk about the Medicaid program as a program at all is almost a misnomer. We have 56 different programs, each tailored to meet the specific needs and circumstances of each State. Whether it's in terms of eligibility, services that will be covered,

methods of provider payments, methods of service organizations, the fact is that States have enormous latitude in how to operate their Medicaid programs and they exercise it.

One of the most frequent complaints from representatives of the States about Federal mandates are the changes that were initiated by this subcommittee in the late 1980's and 1990 to expand mandatory coverage of low income women and children. Thirty-four States exceed the minimum Federal standards in coverage of low income children.

A second chart that is in your testimony in the back, and I'm afraid we don't have a visual display of it, shows that only 38 percent of all Medicaid dollars are spent on services that States are required to provide under Federal law to populations the States are required to cover. More than 60 percent of Federal Medicaid dollars match expenses that are discretionary from the point of view of the States, either in terms of coverage groups or in terms of particular services being covered.

Conversely, within that 62 percent of non-mandatory Medicaid expenditures, States have enormous discretion to change how they allocate dollars or, indeed, to expand or discontinue particular services or coverage to particular groups.

I have observed some of this experience firsthand, if I can take just a minute to talk about a personal experience, having been involved in State health care systems for a long time before I became a Federal official. I was in New York in the early and mid-1980's, in the earliest days of the AIDS epidemic, which is the most serious public health and health services crisis we had faced in a generation. It posed a number of extraordinary challenges to the service system.

In fact, I was personally involved in the development in New York of a number of innovative programs, including the comprehensive AIDS centers based in hospitals, the first AIDS dedicated long-term care facility in the United States, the first AIDS dedicated intermediate care facility in the United States, the first home care program specifically for AIDS patients in the United States, the first adult day care center dedicated to AIDS patients in the United States. All of these programs were undertaken by the State in close collaboration with the private sector and adopted by the State under existing Medicaid law. The Federal Government picked up half of the increased costs being borne by localities and the State as a result of this extraordinary epidemic.

In fact, that sort of responsiveness and flexibility already characterizes the Medicaid program under current law. Ms. James spoke about the growth of managed care in the Medicaid program in Virginia. That is typical of what is happening around the States under current law. Currently, 23 percent of all Medicaid enrollees are enrolled in managed care programs of a wide variety and that number continues to grow very quickly.

I could go on and on with the list of all the different things States are doing in services, in benefits and reimbursement programs and administration. In the interest of time, I won't dwell on that. Let me just suggest, really by way of conclusion, two final points.

One is as the President has made clear, we support legislative changes in the Medicaid law to increase State flexibility in those areas in which States have repeatedly expressed the most concern and where we think good alternatives can be devised: in the adoption of managed care systems; in the development of appropriate consumer protections for patients in managed care programs; and in institutional reimbursement by revising the so-called Boren amendment to something that is more efficacious and flexible.

We don't believe, however, that a block grant either provides adequate protection to the existing enrolled population or, frankly, that the budget resolution provides anywhere near adequate funding to support levels of existing program activity, let alone future innovation.

As chart No. 3 shows, the dollars called for in the Congressional budget resolution are not sufficient in the latter years of the resolution to support the projected increase in the number of people who would be eligible under current law, plus routine consumer price inflation, let alone medical price inflation. The fact is there is not enough money in the budget resolution, no matter how efficient or flexible States are in their administration, to continue to cover everyone who is now covered, let alone to continue to expand coverage to meet growing needs.

That's why we feel that Medicaid reform must be based on the principle of protecting eligibility, assuring coverage for those who are now eligible and those who will become eligible in the future.

I thank you very much and I'm happy to answer questions.

[The prepared statement and attachments of Bruce C. Vladeck follow:]

PREPARED STATEMENT OF BRUCE C. VLADECK, ADMINISTRATOR, HCFA

Mr. Chairman and Members of the Committee: I am pleased to be here this morning to discuss innovations in the Medicaid program. Since its inception in 1965, Medicaid has provided a flexible framework for Federal and State efforts to provide health coverage to low-income Americans. Through a Federal-State partnership, the Medicaid program has fostered substantial innovation in both health financing mechanisms and delivery systems for the diverse populations that Medicaid serves.

BACKGROUND

Medicaid provides health coverage for 36.1 million Americans—children, senior citizens, individuals with disabilities and others—through a partnership between the Federal government and the States which provides States with substantial flexibility regarding eligibility, benefits, payment rates, and delivery systems.

Medicaid covers a broad range of services, from well-child care for low-income children and prenatal care for pregnant women to long term care for the low-income elderly. It also provides a variety of rehabilitative and adaptive services for persons with disabilities, chronic care for individuals with special needs, and supplemental coverage for low-income Medicare beneficiaries.

More than seventy percent of all Medicaid enrollees are mothers and children in low-income families. However, while mothers and children account for the great majority of Medicaid enrollees, senior citizens and people with disabilities account for most Medicaid spending. Nearly seventy percent of Medicaid spending purchases services for this population (Chart 1).

PROGRAMMATIC FLEXIBILITY

Medicaid provides States with leeway to decide who to cover through the Medicaid programs, what benefits are included in the program, and how these services are delivered. The Federal-State partnership also provides States with flexibility to develop program management initiatives and respond to changes in their citizens' health status or coverage needs. In fact, to speak of the Medicaid program is almost

a misnomer. The States and Territories have created 56 different Medicaid programs, each one tailored to fit the needs, the delivery systems, and the circumstances of its State.

Eligibility and Benefits

States largely determine who is eligible for Medicaid within broad Federal guidelines. The largest group of Medicaid enrollees are families who receive cash assistance from the Aid to Families with Dependent Children (AFDC) program. Since the States define their own AFDC eligibility standards, they simultaneously govern Medicaid eligibility.

Similarly, while Federal law requires States to extend eligibility to several mandatory groups—pregnant women, infants and children up to age six in families with incomes below 133 percent of the poverty level, children up to age 13 in families with incomes below the poverty level, and (in most States) individuals who are eligible for the Supplemental Security Income (SSI) program—States may use additional options provided by statute to extend coverage beyond these parameters. For example, States may extend eligibility to institutionalized aged and disabled persons by covering individuals with high medical expenses—the "medically needy". Thirty-four States have expanded coverage for pregnant women and children beyond Federal minimum guidelines, while several States have liberalized financial eligibility standards to cover additional low- and moderate-income women, children and senior citizens.

States are also free to cover additional Medicaid services beyond the ten services required in law. A few optional benefits, such as prescription drugs and clinic services, are covered by almost all of the States. States can choose to offer a wide variety of other medical services, and they can and do change their benefit packages.

States use flexibility in eligibility and coverage of services to customize their Medicaid programs to meet their specific needs. As Chart two illustrates, in 1993 only 38 percent of Medicaid service payments was spent on mandatory services provided to mandatorily eligible individuals. States spent nearly 50 percent of these funds on optional services and populations they have chosen to cover, while another 13 percent was devoted to disproportionate share hospital (DSH) payments.

States also have broad discretion to establish payment rates. Beyond current restrictions on payments to hospitals and nursing homes, States have developed pioneering approaches to paying providers. For example, States have enhanced payments to primary care physicians who decrease emergency room utilization among their Medicaid patients. Similarly, States have developed methodologies for adjusting payments to nursing homes based on the health status and complexity of their patients needs.

Program Initiatives

States also have significant autonomy in day-to-day operations of their Medicaid programs. This freedom enables States to pursue management initiatives that respond to their particular administrative or programmatic concerns, rather than following a Federally-prescribed process.

For example, Massachusetts is pursuing a number of innovative quality improvement initiatives in Medicaid managed care. Massachusetts' asthma management program engages Medicaid-contracting health maintenance organizations (HMOs) in the State's efforts to measure and improve plans' effectiveness in managing asthma care for Medicaid enrollees. Similarly, the Massachusetts Health Care Purchaser Group will, in time, buy coverage for public and private enrollees as a single block while basing purchasing decisions on cost and quality criteria.

In addition, numerous States have creatively responded to the statute's drug utilization review (DUR) requirements. The DUR process reviews prescriptions for appropriateness, medical necessity and cost-effectiveness in order to ensure that patients receive the drugs they need, avoid adverse drug reactions, combat fraud, waste and abuse, and lower drug spending. Innovative State strategies include on-line, point-of-sale systems that provide pharmacists with electronic access to information on the appropriateness of a particular prescription. This process may include screening a prescription against the beneficiary's diagnosis and other prescriptions they may be taking. These systems also enable States to profile physicians' prescription patterns, pay pharmacy claims electronically at the time of dispensing, and verify Medicaid eligibility.

I have also witnessed first-hand the responsiveness and State-level flexibility that is possible within the Medicaid program. In the mid- and late 1980's, before I came to the Health Care Financing Administration (HCFA), I was involved with helping New York respond to an acute public health crisis that demanded a creative response—the AIDS epidemic. While many AIDS patients' health services are covered

by Medicaid, some of these patients had difficulties obtaining services they needed. New York State, the City government, and the provider community responded by developing several programs that emphasized care coordination, heightened criteria for participating providers and increased availability of services for HIV and AIDS patients.

For example, hospitals that are designated AIDS centers must meet clinical standards of excellence and provide case management services for patients with AIDS and HIV-related conditions that coordinate care beyond the hospital's walls. In return, they receive increased Medicaid reimbursement. Related initiatives use a similar approach for primary care providers, home care and long term care for these patients.

New York had the freedom it needed to develop this innovative approach to the AIDS crisis because this flexibility is built into the Medicaid program. No waivers were required, and New York could adapt financing and service delivery programs quickly—and be sure of the Federal share of funding—in responding to the AIDS epidemic.

Managed Care and Home and Community-Based Services

Recently, States have re-designed their Medicaid programs in response to changes in the health care system. This has led to a substantial increase in Medicaid managed care enrollment and enhanced availability of home and community-based services and other care for disabled populations.

States have used program waivers to develop managed care programs that target a number of State-specific priorities. A sample of Medicaid managed care arrangements includes: Alabama's program to enhance prenatal services for high-risk pregnant women; KenPAC, Kentucky's program that pioneered managed fee-for-service systems; and capitated mental health and substance abuse services in Massachusetts and Utah. States have used program waivers and voluntary managed care enrollment to increase Medicaid enrollees' access to services while controlling Medicaid costs. By June of last year, 23 percent of all Medicaid enrollees participated in managed care programs—and this year's enrollment figures should be significantly higher.

Home and community based waiver programs also allow States to manage elderly and disabled individuals' care efficiently. Every State operates a home and community based services program—in addition to the disabled and elderly, States are also serving people with HIV/AIDS, traumatic brain injury patients, and medically fragile children through these programs.

States have also enhanced their Medicaid programs by developing targeted case management programs for Medicaid beneficiaries. Under these programs, States coordinate a range of social, educational, housing, and other social services in addition to medical care. States may choose to deliver these services to a particular segment of the Medicaid population, such as mentally retarded or developmentally disabled individuals, people with HIV/AIDS, high-risk pregnant women and the mentally ill. States define the target group, provider qualifications, payment rates, and any limits on the scope of services.

Demonstration Programs

States and the Federal government have also been deeply engaged in developing Statewide demonstration programs. This Administration is particularly committed to providing States with ample flexibility to test new approaches to covering low-income populations and delivering health services under section 1115 of the Social Security Act.

Historically, States had sought demonstration authority to test relatively narrow changes, such as changes to the Medicaid benefit package, payment methodologies or eligibility requirements for a defined group of beneficiaries or services. Since 1993, States have begun to develop broad, Statewide reform programs under this demonstration authority. To date, we have approved ten Statewide health reform demonstrations, and we are working with States on several additional proposals.

These States will experiment with innovative financing and delivery systems on a broad scale. For example, Florida intends to develop a ground-breaking health alliance system that will broker private health coverage for low-income and uninsured Floridians through a community purchasing network, while Hawaii has created a seamless system of insurance coverage for more than 95 percent of its population through a combination of Medicaid expansions and a requirement that employers provide health insurance to their employees.

States also continue to develop smaller-scale demonstration programs under 1115 demonstration authority. HCFA has approved twenty-four smaller, more targeted demonstrations since January 1993. Some of these demonstrations provide preven-

tive services to low-income children, extend coverage of family planning services beyond the sixty-day postpartum limit, and establish alternative delivery systems in sub-state geographic areas.

BALANCING INNOVATION AND FEDERAL RESPONSIBILITY

Statewide health reform demonstrations are particularly complex examples of State innovation. Through these programs, States can re-allocate their projected expenditures over the next five years to cover additional low-income, uninsured residents, restructure their delivery systems or test other new ideas. These broad-based changes therefore create an immense challenge to both the States and the Federal government, because they require a large number of policy decisions and create a host of administrative and implementation issues that must be addressed. To ensure that these demonstrations are successful, States and the Federal government must work together as partners. Because we have worked with a number of States as they designed and implemented their demonstration programs, we are better able to foster new State innovations by building upon experiences with other States.

We must also balance our commitment to State flexibility within demonstration programs with our responsibility to Medicaid beneficiaries and American taxpayers. We need to ensure that Medicaid beneficiaries receive high quality services and maintain access to health services. We also need to protect Medicaid's fiscal integrity and insure that Federal dollars are well spent in these programs. We not only foster State innovation by supporting these demonstration programs—we also ensure that broader public interests are protected.

We have similar responsibilities in the regular Medicaid program. HCFA provides monitoring and oversight to ensure that Medicaid beneficiaries and taxpayers are well-served by State programs. We also provide significant technical assistance to help States work through program management problems and develop new administrative initiatives.

BLOCK GRANTS AND FLEXIBILITY

Proposals before Congress to block grant the Medicaid program will actually rob States of much of the flexibility they have under the current Medicaid program. While block grants purport to provide States with unlimited freedom to experiment within their Medicaid programs, the $182 billion cut in Medicaid spending required by the Budget Resolution will severely restrict States' abilities to maintain coverage and respond to developing health needs, much less pursue innovations.

To support expected coverage levels, States may have to raise taxes and would need to devote a greater proportion of State dollars to the Medicaid program. The Urban Institute's analysis indicates that if States try to make up for lost Federal funds, they would, on average, have to increase their projected Medicaid spending by 39 percent. Some States, of course, would face even greater cuts in Federal matching payments. As Chart 3 demonstrates, the proposed Federal spending limits would grow at a rate that is only slightly higher than enrollment projections, thus leaving little room for increases in the cost of providing health care. To live within these caps, States would be forced to cut Medicaid eligibility and covered services. While States may have additional freedom under a block grant mechanism, they would have to use this freedom to cut their Medicaid programs in order to absorb significant decreases in Federal Medicaid spending. Innovation, under these circumstances, would be nearly impossible, while creative responses to new public health challenges—such as New York's AIDS program I described earlier—would also be very difficult.

Our experience with Statewide health reform demonstrations indicates how innovations would be threatened within a block grant environment. States have been able to restructure their Medicaid delivery systems and cover additional low-income residents through these demonstrations. However, State spending in these programs has been limited by baseline spending projections under current law, not to the more restrictive confines of the Budget Resolution. Many of these programs could not be sustained if these Medicaid block grant proposals were enacted and further innovation would be stifled.

In contrast, the President's proposals for enhancing State flexibility will further support State innovation. For example, we want to give States more flexibility to develop Medicaid managed care programs by making widely used managed care models a program option, rather than requiring States to obtain waivers from HCFA. Similarly, we are evaluating new approaches to provider payment rates that are more refined than the current Boren Amendment.

We intend to build upon States' current flexibility to dramatically reorganize their Medicaid programs through demonstration programs or Medicaid managed care ini-

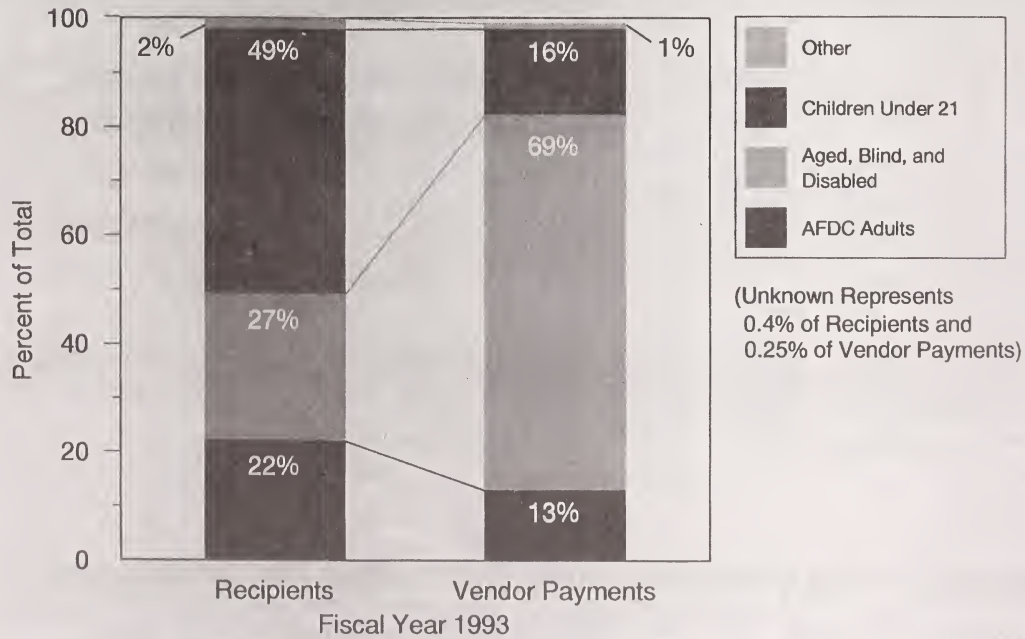
tiatives, develop new management strategies, add additional benefits or make optional categories of individuals eligible for Medicaid. This freedom is available within Medicaid today, because this program was designed as a partnership between the Federal government and the States—with the States having much of the decision-making power.

CONCLUSION

Medicaid has a long history of innovation. States have always been free to design their Medicaid programs to respond to their specific needs. The Clinton Administration has demonstrated its commitment to enhancing State flexibility. We know that States will face new problems in the years ahead, and we believe that the Administration's proposed program structure will better enable them to meet these challenges.

In contrast, proposals that narrowly limit Federal participation within the Medicaid partnership threaten the balance between State flexibility and broader Federal interests, while restricted Federal matching payments would inhibit States' abilities to cover their low-income populations, develop new approaches within their programs, and respond to the challenges ahead.

Percent Distribution of Medicaid and Vendor Payments by Basis of Eligibility



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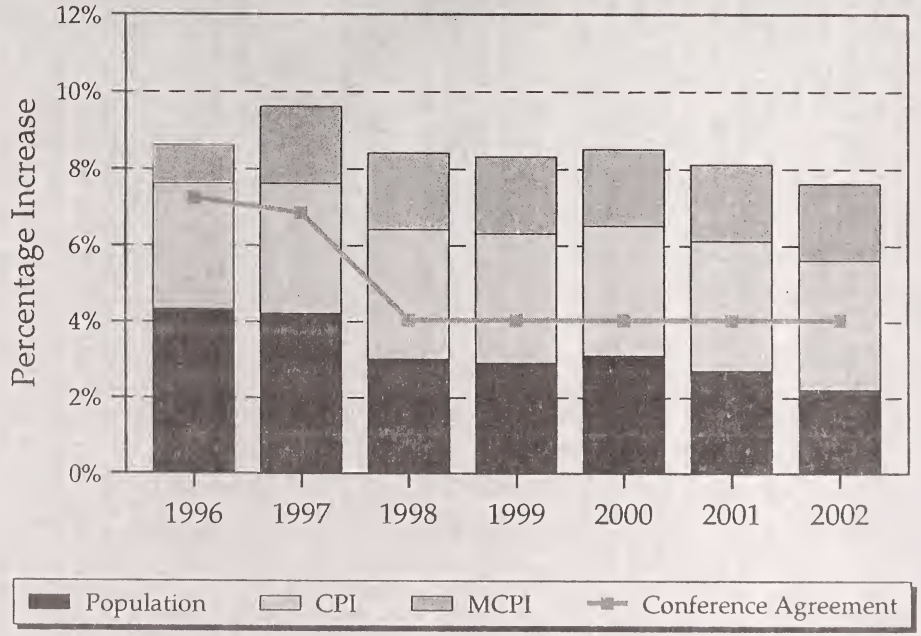
Percent of Total Expenditures for Mandatory and Optional Medicaid Services and Populations FY 1993

		Percent of Total Expenditures
Mandatory Services, Mandatory Eligibles		38%
Optional Services or Eligibles		49%
Includes:		
Optional Services, Mandatory Eligibles	9%	
Mandatory Services, Optional Eligibles	19%	
Optional Services, Optional Eligibles	21%	
Disproportionate Share Hospital Payments		13%
TOTAL		100%

Excludes collections and adjustments.

Medicaid Population and Inflation Growth

CBO Projected Annual Increases 1996-2002 for All Beneficiaries



Mr. BILIRAKIS. Thank you, Mr. Administrator. Ms. James, do you have a response to this latter part of Mr. Vladeck's comments?

Ms. JAMES. Well, I think we have demonstrated in the Commonwealth that we have the ability, first of all, to protect, to provide "adequate" protection to those individuals who are currently eligible. Who better to do that and to provide that protection than the elected officials in the Commonwealth of Virginia as opposed to those who are serving in the administration in Washington.

And in terms of whether or not we will be able to meet the cost restraints that are looming before us, I think we have demonstrated that by operating our program in a fiscally responsible method, that we have been able to do that. Our growth rate in Virginia is now 2.1 percent. And we've been able to do that within the guidelines given by the Federal Government at this point in time and believe we can do an even better job.

So I think that the States are in a position of demonstrating that given the flexibility that we desire to define our benefit package, to negotiate rates with providers, to look at creative and innovative ways of providing access to care for the most fragile in our community, that we can do it.

Mr. BILIRAKIS. So you feel that you have as big a heart and you care every bit as much as the Federal Government in that regard.

Ms. JAMES. Mr. Chairman, I've never met anybody in Washington who cares more for the people of the Commonwealth of Virginia than the Governor and I and the other elected officials in Virginia do.

Mr. BILIRAKIS. Governor Symington, would you have anything to offer? Oh, I hate to say in response to Mr. Vladeck's comments, but basically anything additionally.

I guess I would say this. You've talked about quality. You've talked about caring for your people. Certainly, Ms. James has, as well as you and Dr. Chen and others. But the emphasis in the discussions was on cost containment and that bothers me, even though cost containment is part of the picture. It's a very large part of the picture. It has to be, obviously.

But let's get to quality. Can you, maybe in response to anything Mr. Vladeck said, but also maybe in response to my question, talk about quality? Can you talk about the quality in terms of the services to your people under your 1115 waiver, which I assume would be continued under the block grant or at least pretty darn close to a continuation of what you're now doing under the block grant concept, versus the way it was before the 1115 waiver versus the way it would be if we continued on the current path.

Mr. SYMINGTON. Mr. Chairman, Arizona was reluctant for years to accept Federal dollars and to get into the Medicaid fee-for-service program, but then, in 1982, launched its statewide system and it has worked extremely well. And although we like to talk about the fact that we have saved the Federal Government money through the operation of the program, we're also extremely proud by the quality of the effort.

We estimate that 80 percent of our practitioners in the State participate as primary care givers. The system has really worked extremely well. We provide the full range of Medicaid services, all EPSDT screening and treatment, transportation, ambulatory care.

Our health plan emphasizes preventative care, as evidenced by the findings that well child care, including immunizations, under AHCCCS is more in conformity with the standards of the American Academy of Pediatrics.

So we feel that our program doesn't skip. It's just extremely well thought out and it's a public-private partnership. So you have some market forces at work here to control runaway expenditures. But on the other hand, the level of service is good and people are very happy with it. We've been very pleased with its success.

Mr. BILIRAKIS. Have you had any complaints or constructive criticism, if you will, from HCFA or from any Members of Congress or any oversight group?

Mr. SYMINGTON. Well, in the very beginning, when we started to move into this area, in the first couple years of the program, we had problems with implementation because we were pioneers in the area. Once we got through the first 2 or 3 years, I guess, Mabel, then things started to even out. But we've learned that as we phase in each sort of new aspect of health care, to be very careful to take it slowly because you have to give the system time to adjust.

For instance, phasing in our mental health care efforts has been difficult, but we've made great progress now, and we started in 1990 doing that. We only have one segment of the population left now to bring in. We've brought in the seriously mentally ill individuals and children and then the rest of the adult population.

But we really see the program as a win-win for everyone. It's an extremely efficient system. Recently, when we had 95 bidders come to the table, we could see that even they viewed it as a successful system and we've been able, therefore, to control our costs because there's so much competition.

Mr. BILIRAKIS. Thank you very much, sir. My time has expired. Mr. Waxman.

Mr. WAXMAN. Thank you, Mr. Chairman. Mr. Vladeck, under your leadership over the past 2½ years, HCFA has approved more statewide Medicaid demonstration waivers, 10, than had been approved at any time in the program's 30-year history. And I might make mention of the fact that the Bush administration approved none.

What your track record makes clear is that under the current Medicaid program, when political will exists, innovation happens. We don't have to block grant the program and strip over 30 million Americans of their guarantee to health care coverage in order to have innovation. We certainly won't promote State innovation by slashing Federal spending.

The plain truth is State innovation requires resources, Federal and State resources. In fact, among the States whose demonstration waivers you've approved and who are represented here today, the average annual rate of growth in Federal spending ranges from 7 percent in Tennessee to 16 percent in Oregon. Obviously, these rates of Federal spending growth are far higher than the 4 percent cap.

My question to you is how are these 10 States, whose waivers you've already approved, going to be able to continue to innovate under a 4-percent Federal spending cap.

Mr. VLADECK. We've only had very preliminary discussions with the States in that regard. There are several States that would pretty clearly have to discontinue or never begin their programs. The other States would have to undertake very, very significant modifications.

Of the 10 waivers we've granted to date, only 4 have actually been implemented. In at least three of the instances, the States have not proceeded because of their inability to come up with the additional State funding needed to expand the coverage that was called for in the waivers. So, that accounts for some of the waivers under existing law.

My perception—and some of the folks will be here and you can ask them later—is that as configured, none of the currently approved 1115 waivers could continue in anything like their present form under a proposed 4-percent growth rate.

Mr. WAXMAN. Governor Symington, you've spoken with praise about the way your system is working in Arizona and I've been impressed by it. But the growth in Federal spending is projected in your State to be—this is Federal spending—17 percent. How are you going to be able to handle running your program if the growth is limited of Federal dollars to only 4 percent? Maybe you or Ms. Chen could answer that.

Mr. SYMINGTON. I'll let Mabel.

Mr. WAXMAN. Your program is working well now. When we start limiting Federal growth in what you'll receive, what are you going to do?

Ms. CHEN. The AHCCCS program actually started in 1982. So in the beginning, we only implemented the acute care program, long-term care added on 1989, and mental health we added on starting in 1990. The general mental health will be phased in on October 1, 1995.

We don't know if this 17 percent growth rate is based on which year. So if you're looking at the AHCCCS program, we're pretty much trying to catch up with other State Medicaid programs to cover all Medicaid covered services.

Now, if you look at truly, truly the growth, the population growth and inflation and cost increases, the growth rate will be much lower than 17 percent.

Mr. WAXMAN. What would it be, do you know? What estimate do you project?

Ms. CHEN. If you compare Federal fiscal year 1995 compared with Federal fiscal year 1994, the growth rate will be below 5 percent. I think one thing that's very important in this discussion is the State must be given the flexibility to design and develop the program to fit into the State's and the people residing in the State's needs. That way we can save some money.

Mr. WAXMAN. I understand that. I don't think we're disagreeing over the idea of the flexibility. The question is can you really innovate if you're given flexibility, but less money than what otherwise might be required.

Ms. James, you had made the statement that you have big hearts in Virginia, because you're there and you care about your people. How many uninsured do you have in the State of Virginia?

Ms. JAMES. Well, I'm not sure of what the exact figure is, but I can tell you that we are looking at some programs to take care of even the uninsured population in Virginia. As a matter of fact, we have a new program that just started this year and as a result of that, we believe that that's going to provide services to even that population.

Mr. WAXMAN. How many State dollars are you going to have to put into that new program? If I could just complete this, Mr. Chairman, because I'm trying to get to a point.

Ms. JAMES. Sure. I'm not sure what that's going to be, but we're looking at some things, including an indigent care trust fund in order to do that.

Mr. WAXMAN. And do you have any concerns, like those we'll hear later from Ms. Thorne from the State of Oregon where they cover the indigents now, that they're going to be a magnet for people coming from other places where they're not as big-hearted, perhaps not as financially able to do as much as you hope to do in your State?

Ms. JAMES. That is not a concern because I believe that the program that we run in Virginia is one that is compassionate, as you say, and, at the same time, fiscally responsible. So I think that we will provide a basic level and care of service in Virginia. I doubt that Virginia will become the magnet that you project it will be.

Mr. HASTERT [presiding]. The gentleman from Virginia, Mr. Bliley.

Mr. BLILEY. I thank you, Mr. Chairman. Ms. James, I'd like, too, to welcome you and the rest of the panel. I apologize for being late, but one of the hazards of this job is too many meetings all at the same time.

You said something in your statement that seems to get at the heart of the need for State flexibility in the Medicaid program. You stated that "Nobody knows what the people of Virginia need better than do the people of Virginia." Would you elaborate on this perspective?

Ms. JAMES. Certainly. I think one of the statements that's been made earlier this morning is that we cannot sustain the level of growth in the Medicaid program that we have without looking at what are the covered services that are going to be included in any sort of a benefit package and that in order to provide adequate protection to those Medicaid recipients, that somehow we must maintain Federal control of the program.

I guess I would just like to suggest that in looking at what that benefit package ought to be, what are the needs of the people in the Commonwealth of Virginia, what do we want to cover, that, in fact, those decisions are best made at the local level. Those decisions are best made by the people of the Commonwealth of Virginia.

So I would say that that would be one good example of how we believe that we could use the flexibility of a block grant in order to design the program so that it would best meet the needs of the people in the Commonwealth.

Mr. BLILEY. Mr. Vladeck, if I understand your perspective completely, you're suggesting that the section 1115 waiver process gives States all the flexibility they need. However, the section 1115

waiver process itself is so complex and so time-consuming that few States have ever received one. In fact, we have heard from a number of Governors and other State officials horror stories about the months and years it takes to get approval and the tremendous cost that is involved in satisfying all of HCFA's application requirements.

To your left there on that table is a 3-foot stack of papers which represents just one application, as proof of this. Is it not surprising that only 10 States have ever received a section 1115 waiver? Given these facts, are you suggesting that the section 1115 waiver process is even comparable to the block grant reform initiative as a tool to increase State flexibility?

Mr. VLADECK. Mr. Chairman, if I may, let me just clarify some of the facts about the 1115 process. Since the Clinton administration came into office, you're correct, we've approved 10 statewide health reform demonstrations. We've approved a total of 34 section 1115 demonstrations. That contrasts to the record under the previous administration, in which a total of 16 1115 demonstrations were approved and a total of zero statewide health care reform demonstrations were approved.

The fact is that the 1115 process requires the amount of paper it does, although the instance there is exceptional, and the amount of time it does because we are quite insistent on 3 or 4 basic considerations which would be lost in a block grant. One is that existing eligibles are no worse off as a result of the alternative program than they are under the status quo; second, that new delivery systems bring with them adequate mechanisms for accountability and reporting, to be administered by the States; third, that the Federal budget be protected in terms of Federal outlays under the 1115 as opposed to under current law, which is generally the most complex and time-consuming part of our discussions with the State; and, fourth, that particular vulnerable populations which have particular needs and particular protections under Federal Medicaid law, like the mentally ill or the mentally retarded, are adequately protected under the 1115 program, as well.

The fact is that AHCCCS is a success, the Oregon program is a success, and TennCare is a success. Nothing that important and that good comes automatically. But I would also argue, although I'm not sure the representatives of those States would agree with me, that those programs are significantly different from what the States initially proposed to us. Many of the changes that were required in the course of this process have produced significant improvements in the program prior to its implementation.

Mr. BLILEY. Thank you. Thank you, Mr. Chairman.

Mr. HASTERT. The time of the gentleman has expired. The gentleman from Michigan, Mr. Stupak. Five minutes.

Mr. STUPAK. Thank you, Mr. Chairman. Ms. Chen, in your last answer, are there some Medicaid programs that you're supposed to be providing in Arizona that are not yet on line, which you have not yet provided? I sort of got that idea from your last answer to a question from Mr. Waxman.

Ms. CHEN. I didn't quite understand your question.

Mr. STUPAK. Are there some services that you should be providing under Medicaid that Arizona is not providing now?

Ms. CHEN. What I tried to explain is because the Medicaid program in Arizona started in 1982 and we implemented acute care, the regular health care program first, and then added on the long-term care and behavioral health later on.

We phased in the behavioral health program. The last piece, the general mental health, will be phased in October 1, 1995.

Mr. STUPAK. So you're not providing mental health services right now.

Ms. CHEN. We do provide mental health services to seriously mentally ill and to children who need mental health services. For the regular population, for adults, we only provide emergency mental health services at this time.

Mr. STUPAK. My concern is the flexibility that you are all claiming you want will depend upon the size of your budget and I'm real concerned with the $184 billion in proposed cuts over the next 5 years. Does flexibility mean less coverage?

I understand what Arizona is trying to do in the phase-in. It makes some sense and looks like a pretty fair program, but in the bill that is currently introduced, the Senate Bill 844 that I indicated, the only bill pending right now in Congress, Senate Bill 844, that's scheduled to go on-line October 1. That's about 67 days.

I see the phase-in period that Arizona has had. I heard from Ms. James, who has a number of programs that started July 1 and also January 1. I'm concerned that come October 1, there's going to be less money and that flexibility—is the rug going to be pulled out from underneath some of these programs. That's my concern.

But before I came to Congress, I was a police officer and I've seen these crack cocaine babies and been involved in some of those cases like that and I was really concerned about the program that the Attorney General from South Carolina mentioned. Mr. Vladeck, could I ask you a little bit about that one?

Mr. HASTERT. Gentleman, I think the Governor would like to respond here to your question.

Mr. STUPAK. Well, let me go on this South Carolina one. It was pretty emotional testimony and I really have some questions on this crack cocaine baby one.

What was the issue there? Were there other issues there? What happened there? Why would that be shut down?

Mr. VLADECK. Mr. Stupak, the South Carolina issue was not a Medicaid issue, per se. I've talked to my colleagues in the Department and I have the paper trail associated with this issue and I'd be happy to share it with the committee, if you would like. But there were two issues with the South Carolina program.

First, the Office of Civil Rights in the Department of Health and Human Services determined, on the basis of preliminary investigation, that 65 percent of the women who tested positive for cocaine in the hospital in question were African-American and all of the women who were threatened with criminal prosecution were African-American. Serious civil rights questions were raised on the basis of that data.

When given that data, the university voluntarily dropped the prosecution component of the program. The most serious issue involved questions of testing patients without informed consent, in violation of Federal rules for biomedical research. In fact, the major

set of HHS bureaucrats who were involved in this case were from the National Institutes of Health. They found significant non-compliance with the Federal law on protection of human subjects in this project and did, as is required by the law in such instances, call the attention of the university to the fact that if they remained out of compliance with Federal law on protection of human subjects and experimental research, they did run the risk of loss of Federal funding. At that point, the university entered into an agreement with the Department to change the program in order to come into compliance with that part of the law.

And I'm happy to submit the written record in that regard for you and the committee's use.

Mr. STUPAK. So if I understand you correctly, there was no informed consent before testing. There was some question about whether the minorities were automatically placed into a program and not given the option. And last but not least, South Carolina could still continue their program if they chose to, provided they went with the informed consent route.

Mr. VLADECK. That's correct, as I understand it, sir, yes.

Mr. STUPAK. Thank you.

Mr. CONDON. Can I respond to that? Because it's really good to meet somebody and put a face to the rules that come down. To have him say this amazes me. Here is the translation when you get down to Charleston, South Carolina from really smart people in Washington. He's saying that we voluntarily stopped this program.

Well, here's the voluntary—if you don't stop this program, all of your Federal funds are cutoff. Now, you're a police officer. I respect law officers. I've worked with them all my career. You know that wouldn't be voluntary in a court of law. And to address the issue of racial discrimination, that's the other one that really amazes me. The police chief of Charleston happens to be an African-American, Ruben Greenberg, who was really behind this program.

Now, I don't know what numbers he's coming from. All I can tell you is everyone who came in there was tested along race-based—race-neutral criteria and the rules were the same for everybody. Now, as I recall—and I'm amazed they're calling this a prosecution program, embarrassed to even say it's prosecution, because we had something like 100 people test positive in a couple months period of time. Of the 100, I think only 20 decided not to go to drug treatment and those were arrested.

I don't know what the numbers show, but I can tell you that we only brought three people to court, because we wanted them to go to drug treatment and we offered them probation when they got to court and throughout the whole process, if you go to drug treatment, we will give you amnesty. They all eventually went to drug treatment and I can tell you that not one person was sentenced to a term of incarceration.

Mr. HASTERT. The time of the gentleman has expired.

Mr. STUPAK. Mr. Chairman, if I may. I think the biggest violation he said was that people were subject to testing without their consent. If that's the case, you don't have to be a police officer or an attorney general or an administrator of HCFA to know that when I go to the hospital, I have to sign for treatment. If I'm not

doing that and treatment or experiments or whatever you want, testing being done on me without my consent——

Mr. HASTERT. The gentleman's time has expired.

Mr. STUPAK. [continuing] certainly in violation of law.

Mr. HASTERT. Governor, would you like to respond briefly?

Mr. CONDON. If I could just respond briefly. They did sign a form. They were given the consent.

Mr. HASTERT. Governor.

Mr. SYMINGTON. Yes. I'd like to address Mr. Stupak's—this argument or the discussion that I hear in Washington about the deep cuts and to share with you the perspective of a Governor from the southwest who balances his budget every year and has to by our constitution.

What we see aren't necessarily deep cuts. We see reductions in levels of increase in programs, which, to us, is different. There's quite a difference between that and cuts. Cuts, to me, imply that you have your base budget and you're going to cut deeply into your base budget, and that is not the case, as I understand it, with what Congress is contemplating, No. 1.

No. 2, I really don't know what alternative you have in the real world, because the Federal Government is lurching toward a very difficult financial situation. These welfare and health care programs are running away with the national wealth and we've got a problem and we can't stick our head in the sand. And the States stand there as a wonderful alternative for the Federal Government to look to for innovation in a time of great difficulty.

And our AHCCCS system is a perfect example of what innovation can happen at the State level, with limited resources, I might add. And if you compare, for instance, our system to the State of New York, where we're less than half in terms of our per capita funding of beneficiary, but we provide the same level and quality of service, but we do it better. There's enormous room for innovation. Dollars don't necessarily govern.

I'll tell you where dollars come into play here. If you have fewer dollars, it forces people to innovate. You will bring about change. That's what America is so good at. When we find ourselves in a tough spot, we find new ways to do things, new ways to provide services.

So I don't see this as a zero sum game where a lot of people are going to get hurt. I see it more as a federalism issue where the States will fulfill their true purpose in this partnership of governing in America and will develop and innovate and do the kinds of things better, I think, at the local level than the Federal Government can do at the national level.

Now, my experience with HCFA has been very unsatisfactory, with all deference to the speaker to my left. No pun intended. The problem with HCFA is when we started on our welfare reform waiver, we submitted to them a letter in August. The first time we heard from them was in late December of the same year. The process was long and arduous and was not really beneficial. We did get our waiver, however, but we had been delayed a year.

So this November, our welfare reform program will be coming forward. But, anyway, my experience has been very difficult with HHS, I might add, not necessarily with HCFA.

I would like to say, too, finally, that the question you brought out about our general mental health, which is being phased in, now is the last component of our AHCCCS system, that would only have a 1 to 2 percent effect on our budget. So it's about $20 million, which is a minor aspect of the program.

Mr. STUPAK. I guess my concern is it's been 13 years since you began your phase-in. It's still not completed. You mentioned New York. New York does have a full tier of services being provided, as required under Medicaid, and Mr. Waxman says you're going to have a 17 percent——

Mr. HASTERT. The gentleman's time has expired.

Mr. STUPAK. [continuing] increase. I just want to finish this.

Mr. HASTERT. No. The gentleman's time has expired. The gentleman from North Carolina, Mr. Burr.

Mr. BURR. Thank you, Mr. Chairman. Secretary James, Mr. Vladeck said in his opening statement that only 38 percent of the State's expenditures are federally mandated. Can you comment on that just a little bit, sitting in the position that you are? Is that some comforting message?

Ms. JAMES. Well, I think that there are several levels of mandates that we get. There are those that come through the regulatory process and then there are those that come through the statutory process. And when we look at things like the Boren amendment and what that's cost the Commonwealth of Virginia, as well as the things that are required by the regs that come out of HCFA, those things that cost the Commonwealth of Virginia, when we had had no part of the decisionmaking process in terms of how we'd want to operate our program, I think it is a little disingenuous to State that there is little or no impact on the things that come from the Federal Government on the Commonwealth of Virginia.

Mr. BURR. Let me ask you this question, Secretary. If we were to block grant Medicaid and if we, in fact, wrote guidelines to dictate 40 percent of the block grant, would the block grant be successful?

Ms. JAMES. Absolutely not.

Mr. BURR. Why?

Ms. JAMES. I don't think it would be successful because you are not giving us, if you are going to maintain control of 40 percent of the program, the flexibility that we need in order to operate what we believe to be a program that would give access to care to the frail in the Commonwealth of Virginia, as well as to be fiscally responsible.

I would just add that when we look at the growth of Medicaid and when we look at the increased Federal spending, and I've heard the question asked of several other States, would you be able to operate within the 4 percent guideline, and I notice that question hasn't come to Virginia and probably because the answer is we are currently, with only a 2.1 percent expected growth rate in Medicaid.

So I guess in answer to your question, we have been operating a program with the limited flexibility that we have. We believe with additional flexibility given to us, the ability to negotiate provider rates, the ability to set our own benefit package, the ability to expand our managed care programs without going through that

costly process that you see over on that table, that we could do both. We could, in fact, provide excellent quality of care and contain costs.

Mr. BURR. I'm very tempted to make a suggestion that we adopt the Virginia plan for all 50 States, but, in fact, that wouldn't work, would it?

Ms. JAMES. No, it wouldn't.

Mr. BURR. Every State is different. Mr. Vladeck, welcome and thank you. I certainly have told you before I have a great deal of respect for how many times you're having to get up and talk about this and really defend what I think is the status quo. You said in your testimony that every State already has their own plan.

In fact, don't they have to meet your rules, though?

Mr. VLADECK. Well, there are certain rules that have to be met and then there are certain areas of very broad Federal and State discretion.

Mr. BURR. And if they want to deviate from those rules, then they're faced with some type of waiver, the equivalent of what would be there on the table.

Mr. VLADECK. It depends on the rule, sir. These kinds of 1115 demonstrations involve very broad-scale changes from what is permissible under existing law and require a lot of paper. Most of the changes States wish to undertake in their programs are on the order of 1 or 2 pages. Many of them are using preprinted forms that we supply to them.

If they want to add a benefit, reduce a benefit, change a method of provider reimbursement, or add a new service, for example, the amount of paperwork is minimal and the amount of time it takes to receive approval is minimal, as well.

Mr. BURR. Let me, if I could, probe a comment that you made to the National Journal, where I think you said that implementing block grants of Medicaid and slowing the growth of Medicaid to 4 percent would be, and I quote from that, "a real cut in services." I guess my question to you would be, given that the President's budget slows the growth to somewhere between 6 and 6½ percent, where specifically does the President's plan cut services? I think that might be a good place for us to——

Mr. VLADECK. The President's plan, to begin with, identifies the maintenance of current eligibility and the current entitlement for current eligibles as the core of the proposal.

Mr. BURR. But, specifically, where does he cut services in his proposal, which cuts $121 billion? We cut 182.

Mr. VLADECK. The number isn't $121 billion.

Mr. BURR. Excuse me?

Mr. VLADECK. That's not the correct number. The correct number is $54 billion over the period.

Mr. BURR. We have to assume the CBO numbers up here.

Mr. VLADECK. Well, under the CBO numbers, the President's proposed changes are $54 billion.

Mr. BURR. Well, that's one I guess we'll disagree on. But do you suggest that under the President's slowing of the growth that, in fact, he cuts services?

Mr. VLADECK. The States might very well cut services.

Mr. BURR. Does that mean that, in fact, block grants can possibly stay off the President's suggested cuts in services? That by allowing the States the flexibility, that, in fact, the States won't have to reject services?

Mr. VLADECK. States have the flexibility to cut services. Only a quarter of the services provided under the Medicaid program are mandated by current Federal law, most of those that are mandated. It's hard to imagine that States would not cut under a block grant. Whether you take 6 percent out of the program or 20 percent out of the program is a difference of more than just minor detail. It's the difference between whether you can maintain current levels of coverage or whether you can't.

Mr. BURR. Mr. Chairman, one last question, if I may. I've got a chart that I need to put up, but I think this makes one of the strongest cases that the efficiency of managed care in Medicaid comes from the Federal waivers that you, in fact, administer, and that's the 1915(b) demonstration waiver. Twenty-four States and the District of Columbia have 1915(b) waivers and according to State financial reports filed with your Agency, they all achieved initial and ongoing savings after switching to Medicaid managed care. In fact, the national weighted average for these savings is nearly 10 percent.

Now, based on the evidence that HCFA, your organization, itself has collected, how can we make any other conclusions other than that managed care in Medicaid achieves real long-term savings?

Mr. VLADECK. It does, sir, but those savings are already in the baseline. In fact, if we went to 100 percent Medicaid managed care over the budget window, it would, as compared to the baseline, only save a quarter as many dollars as are called for in the Congressional budget resolution.

Mr. HASTERT. The time of the gentleman has expired. Mr. Deutsch, the gentleman from Florida.

Mr. DEUTSCH. Thank you, Mr. Chairman. Governor, we've heard the number of your increase of Medicaid costs at 17 percent, and I'm just trying to fix what your cost increases have been over the last several years, if you have a number that you feel comfortable discussing with us over the last 5-year period.

Mr. SYMINGTON. Seven percent a year. Go ahead.

Ms. CHEN. The Medicaid expenditure increase in Arizona compared to the 1994 Federal fiscal year, 1994 and 1995, the increase is less than 5 percent. But if you compare 1994 to 1993, we have a higher increase because we are in the process to phase in the behavioral health program.

Mr. DEUTSCH. So that year was 17 percent.

Ms. CHEN. We don't have a 17 percent increase, but we don't know the base of the calculation for the 17 percent.

Mr. SYMINGTON. We don't know where that number came from on the chart.

Mr. DEUTSCH. Maybe you ought to hire our staff, but they're telling me it's in 1993, the 17 percent, and that was an aberration. It was just a bad year in Arizona. It was a very hot year. You had behavioral problems. I'm being serious. I mean, I'm being flippant, but I'm being serious at the same time.

Why was 1993–1994 a bad year or 1992–1993? Because I guess one of the perspectives I have, Arizona, I think, at least from my impression, Arizona is similar to Florida, that you are a relatively fast growth State.

Mr. SYMINGTON. I think there is a mistake in the terminology here about the 17 percent. I think what you're talking about is that it was reported that our long-term care program is projected to grow at 17 percent a year. I think that's the derivation of that number, if I'm not mistaken.

And our response to that——

Mr. DEUTSCH. Hopefully I will submit things in writing, but, again, our staff, who has been pretty consistently right every time they've given me a number, is telling me that it's both acute care, not just long-term care. You have numbers, but, to me, that is a fundamental question that I would hope that someone in your office knows that number, because, to me, it is a very, very, very critically relevant number, what your growth rate is, because you have testified to us that you want us to tell you that you support this block grant program, which, to me—again, Arizona, as far as I can tell, is probably about a State as close to Florida in terms of projection and things like that as any State in the country, where our Governor has been adamantly opposed to this program for really two specific reasons, which seem to fit Arizona, as well.

And I really welcome you to tell me I'm wrong, but, No. 1, that what the specifics of the proposal are is cap it at 5 percent regardless, at least at this point, not taking into account growth or not taking into account age of senior population in terms of statistical costs of older seniors, which Arizona has a similar problem to Florida on.

So if you're saying give us a block grant, as Congress has told you, we're not going to take into account growth, which is No. 1. And, No. 2, as far as I can tell, Arizona has been relatively efficient, as Florida has been, in terms of innovative things today to deal with costs. And the proposal that we are passing or that my colleagues on the other side have been proposing, at least at this point, does not take into account at all prior efficiencies as they've been made in States like Arizona and Florida.

I guess the bottom line is whatever your growth rate is, if what we're telling you is we're going to give you less than your growth rate and you've already done all these innovations, unless you've got some magic wand, I don't see how you can possibly say you can provide the same level of service.

Mr. SYMINGTON. Well, Mr. Deutsch, one of the magic wands is to remove a lot of the Federal regulatory burden from the process to give the States the flexibility within the block grant to redesign programs and all the eligibility formulas, which are just mind-boggling in complexity.

Mr. DEUTSCH. Again, sometimes I hear regulatory burden, regulatory burden.

Mr. SYMINGTON. But, excuse me, let me make my point.

Mr. DEUTSCH. And at what cost?

Mr. SYMINGTON. Excuse me one——

Mr. DEUTSCH. Regulatory burden——

Mr. SYMINGTON. Mr. Deutsch, let me——

Mr. DEUTSCH. I only have 5 minutes.

Mr. SYMINGTON. Mr. Deutsch, I've talked to your good Governor. I've talked to your good Governor, the Governor of Florida about this issue. On one thing I think there is a common view, and that is that the high growth-low benefit States definitely need to be accommodated in the Medicaid block grant formula, because our population in the next 10 years is going to grow somewhere between 17 and 19 percent.

And the fact of the matter is if we lock into 1994 base year funding plus 4 percent for inflation, that creates tremendous problems for high growth-low benefit States, and we all know that. But I believe that we're going to work that out, because I believe in the principle of block grant, because I believe that the action should be in the States, that we need to diminish the Federal presence over this area of domestic policy, and that we will do better handling it at the State level, but we need the flexibility and we need a formula that will acknowledge the differences between the various regions in this country.

And I believe we're going to get there and then I think we're going to have a much better world in terms of the management of these systems.

Mr. HASTERT. The gentleman's time has expired. Mr. Vladeck, there's been a lot of talk about cuts today and you've talked about them. However, the proposal that the Republican side of the aisle is trying to put forward is, as we've said before, really not cutting money. We're trying to limit growth. Slowing the growth rate in the program is certainly our goal.

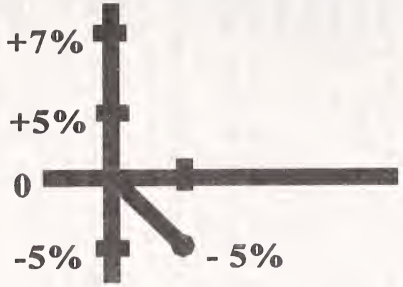
The block grant would grow at approximately 5 percent annually. Now, let's talk about a real cut, Mr. Vladeck. This is the administration health care bill from last session. You have it before you, I think. It's 1,300 pages.

Would you read lines 20 on page 1,296 to line 5 on 1,297? I think you have it before you. Would you please read that?

[The chart referenced follows:]

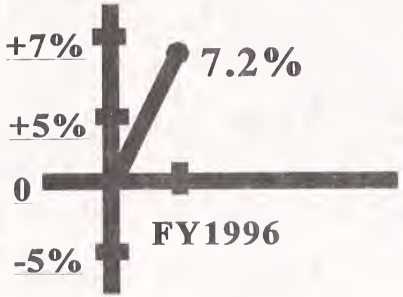
A Medicaid Definition Primer

Clinton in 1993: This is a CUT in Medicaid



Section 9101 (Clinton Bill):
"The Secretary shall provide each year for payment to each regional alliance of an amount equal to the Federal Medicaid assistance percentage of (a) 95 percent..."

Republicans in 1995: This is GROWTH in Medicaid



Medicaid Growth Rate for FY96, per the Conference Agreement on Budget Resolution

Mr. VLADECK. "In general, the Secretary shall provide each year for payment to reach regional alliance an amount equal to the Federal medical assistance percentage, as defined in section 1905(b) of the Social Security Act, 95 percent of the sum of the products described in section 9011(a) for the State for that fiscal year, plus the sum described in 911(c)."

Mr. HASTERT. So that 95 percent is actually a 5-percent cut from the base, sir, and that's your proposal on Medicaid. Now, our proposal grows 5 percent above the base.

Mr. VLADECK. That's a misstatement, sir. That was for coverage of people who are already in the Medicaid program.

Mr. HASTERT. It's a Medicaid cut.

Mr. VLADECK. Whereas we were providing for insurance coverage for every other uninsured person in the United States under the same legislation.

Mr. HASTERT. Is 95 percent——

Mr. VLADECK. It's apples and oranges.

Mr. HASTERT. [continuing] from the base a cut or is it not a cut?

Mr. VLADECK. Ninety-five percent is about what we average when Medicaid programs——

Mr. HASTERT. Is 95 percent a cut or is it not a cut?

Mr. VLADECK. It depends on the context, sir.

Mr. HASTERT. It's a cut, sir. Let me tell you in basic grammar and vernacular, it's a cut. We're growing at 5 percent. So there's a difference. I think you ought to watch what you say.

I want to also say, Mr. Vladeck, that a stack of documents over there represents the Illinois application for a waiver which has been sitting there about a year now, with a lot of bureaucracy and inquiry and response. The State of Illinois still hasn't got that waiver approved; this is costing the Federal Government and the State of Illinois hundreds of thousands of dollars, millions of dollars, while people are not benefiting from it.

So you may respond to that, but we certainly would hope that your bureaucracy would see to it and expedite that.

Mr. VLADECK. Mr. Hastert, sir, as soon as the State of Illinois provides us with a plausible plan for paying the $700 million in back obligations they have to hospitals in the State, we should be able to approve their waiver very quickly thereafter.

Mr. HASTERT. Well, until we do or are able to expedite, and I think the State of Illinois will work out that plan, you're just making situations worse and you're probably the cause of that. I yield back my time.

The gentleman from Florida, Mr. Stearns.

Mr. STEARNS. Thank you, Mr. Chairman, and good morning to the witnesses. Governor Symington, I wanted to just follow up a little bit on the discussion that my colleague from Florida, Representative Deutsch talked to you about, and you mentioned two of the things that you want are flexibility and the formula.

Perhaps you would like to continue this discussion. You may want to add something. But I think both he and I have voiced our concern in these committees about the current distribution formula for Medicaid and what would be its impact.

You've mentioned the flexibility, so we give you the flexibility. If you were me, what would you advocate with the formula?

Mr. SYMINGTON. First of all, I'm not sure that there really is a formula at this point in time. There have been various formulas put out there. But in a general context, we need to take into account the growth of population in the high growth States, because a base year funding with a 4-percent inflation obviously impairs a State whose population, over a 10-year period, may grow by 17 to 20 percent.

So some people are going to have to readjust. There will be some winners and losers. And the question is how do we work that out in the formula. I believe it will be worked out, but that's an issue that I really don't have too much inside knowledge about right now. I understand it's being worked in the halls of Congress and that the spirit of compromise is in the air.

None of us want to see the block grants fail, though. We will find a formula that will work, because the States want the flexibility, they want the block grant, they want more control over their destiny in this arena, because we're very frustrated working with the bureaucracy.

Mr. STEARNS. I can respect that. I think basically you're saying we can spend this money more wisely than the government can because we're closer to the problem and we understand it better. And, generally, compassion works best if you can understand the problem, and actually it works to the detriment of people if you don't.

What effect, Governor, does the Boren Amendment have on your State?

Mr. SYMINGTON. Well, it creates just a problem in terms of the funding, and maybe Mabel would prefer to give you chapter-and-verse on that. Mabel, why don't you tell him exactly.

Ms. CHEN. The Boren Amendment in Arizona, because we have a statewide managed care program, according to HCFA requirements, the Boren Amendment only applies to those people who are served in the fee-for-services program. We do have a very small fee-for-services program, at any time with about 8,000 to 10,000 people in fee-for-services because they are waiting to be enrolled in a managed care program.

The problem created for Arizona is even for such a small program, we still have to go through the hospital reimbursement resetting to be fully in compliance with the Boren Amendment to set up a reasonable hospital rate for the small fee-for-services program.

Mr. STEARNS. So you would like the Boren Amendment changed so that you could do it for HMO's and for other special fee-for-service plans that you set up. Is that fair to say?

Ms. CHEN. Yes. In the program, we would like to see maybe the responsibility can be given to the State to develop the reimbursement rate for all the providers.

Mr. STEARNS. Okay. This is a question for all the witnesses, and let me start off with Mr. Vladeck, the Administrator of HCFA. You've been before us before and you've indicated that there is fraud, waste and abuse in the Medicaid program, of either 10 or 12 percent. I think that's the term you used, and you gave a distinct figure.

You told, as I remember, when you talked about Medicare and Medicaid together, you said it could be as much as $30 billion.

Now, if the States—it's block granted to the States and they privatize and use more of the commercial companies, won't they bring down the amount of Medicare fraud, waste and abuse? I guess my point is if there's 10 or 12 percent of waste, fraud, and abuse, and we had this 5 percent cap and the States can rid of the waste, fraud, and abuse, won't they then be at 15, 17 percent savings? I mean, they'll have a lot more room to work with if they can actually get rid of the waste, fraud, and abuse.

Can you just say yes or no and maybe one sentence, if you disagree?

Mr. VLADECK. The States have as much incentive now to eliminate waste, fraud and abuse as they would under a block grant. In fact, they have earmarked Federal funding now, which not all of them have chosen to take. We have active investigations in at least two States in which the problems of potential fraud in the Medicaid program are complicated by ownership interests of State officials and some of the providers.

So the answer is I don't know how a block grant makes the problem of going after fraud and abuse any different than it is under current law or makes it certain we'd be more successful.

Mr. STEARNS. Mr. Chairman, I have no more questions, but I'd appreciate, since I've asked the question, if they could just go through the panel and answer yes and no to that. Is that possible?

Mr. HASTERT. We're limited on time. We have two more questioners and then we have to close it out.

Mr. STEARNS. Okay.

Mr. HASTERT. Mr. Ganske.

Mr. GANSKE. Thank you, Mr. Chairman. If I ask a question that's been asked before, my apologies, since I had to be in and out. Governor Symington, I don't know whether it's been asked, but it's my understanding that Arizona came into the Medicaid program kind of late.

Mr. SYMINGTON. That's correct.

Mr. GANSKE. And why was that?

Mr. SYMINGTON. It was because Arizona really was reluctant to take in the Federal money to begin with and felt that the Medicaid fee-for-service program was an extremely tough proposition financially. The State was scared of it, for the reasons that are now obvious to all, and wanted to develop its own system. And then the waiver process, I guess, got started in the early 1980's and we went in for our 1115 waiver and got that in 1982, 1982–1983.

Mr. GANSKE. How long did that take you to get that waiver?

Mr. SYMINGTON. The initial waiver process? I think it took a couple of years, 2 years, and so then we embarked on a totally new program, it was the first one in the country, for a statewide capitated system, managed care system, covering both urban and rural areas. And it was rough in the beginning. We had our problems, but we've learned as we've gone along and now it's a very successful, efficient system.

Mr. GANSKE. Do you do competitive bidding?

Mr. SYMINGTON. Yes, we do. What we do is actuarial work to find out the range of what an acceptable fee would be. We don't give that out, though. We hold that back and then all the bidders come in and basically bid for the contracts. And then if they're below the

actuarial level that we think is safe, we try to nudge them up, and if they're above, we try to nudge them down through negotiations. So that we're very comfortable with the pricing, because we've done a lot of our own cost estimating, in effect, as if it were a construction project and you were the owner and then you go with the bid knowing what you think it should cost, and it's worked quite well.

Mr. GANSKE. Do you choose just one provider?

Mr. SYMINGTON. No, we have 14.

Mr. GANSKE. Does somebody win?

Mr. SYMINGTON. We have 14.

Mr. GANSKE. You have 14, then.

Mr. SYMINGTON. Yes. And, in fact, in the last round of bidding in our State, we had 95 interested parties basically bidding. So that helped drive the price down.

Mr. GANSKE. So there's a mechanism whereby a Medicaid recipient has a wide choice.

Mr. SYMINGTON. Wide choice.

Mr. GANSKE. And, thereby, if one of the plans is not offering quality care, the marketplace enters in because somebody can switch into a different plan.

Mr. SYMINGTON. Right. They all have a primary care provider and there's a lot of personal contact and high satisfaction on the part of the client.

Mr. GANSKE. Thank you much. I see my time has expired.

Mr. HASTERT. The gentleman's time has expired. The gentleman from California, Mr. Bilbray.

Mr. BILBRAY. Thank you, Mr. Chairman. Mr. Governor, we're neighboring States, many differences, but we do have some things in common. One is that we're both high-growth States. California is growing at 11 percent. The other issue is obviously one that the United States is beginning to recognize, and that is the issue of illegal aliens and the impact across the board.

I would ask your consideration and your comments about the burden-sharing that States are bearing now for illegal immigration. Could you elaborate on your written testimony on how the block grant would have to be structured to compensate or straighten out this disproportionate amount of burden for something that is totally a Federal obligation?

Mr. SYMINGTON. Well, with regard to the illegal immigration issue, we have always viewed that as a Federal problem and a Federal burden. It should not be borne alone by the taxpayers of Arizona, because in the Constitution, the Federal Government is charged with basically controlling our international border. So if this problem ends up in our midst, it's because the Federal Government hasn't done the job it's supposed to do in terms of controlling the border. So we feel that that's a Federal responsibility.

And it does create a problem, but I think less so in our State than in California, from all I can read from the statistics.

Mr. BILBRAY. Yes, $600 million in California. I certainly hope it's less of a problem in Arizona.

Mr. SYMINGTON. That's right. Actually, when we look at California, we just use a factor times 10. We either divide by 10 or we multiply by 10 and that puts it all in proportion for us. Our prob-

lem, proportionately speaking, is a little less than yours in that area.

Mr. BILBRAY. But you do agree that that has to be considered into whatever formula we ended up with?

Mr. SYMINGTON. Absolutely. And that, again, points to the problem of having a one-size-fits-all Medicaid system driven from Washington that doesn't acknowledge regional differences. Every State is different and the idea of the block grant, I think, should encourage this sort of flexibility and diversity of approach to dealing with these issues, because we have problems in Arizona that just you don't find in Massachusetts and other States.

Mr. BILBRAY. We're starting to find them a little more as time goes on, but in California, 40 percent of our Medicaid births are for children of illegal aliens, 96,000 just in 1992 alone. While people talk about wanting to defend and protect this program that has been around for so long, so few of them are willing to stand up and say wait a minute, we have to take a serious look at whose gaining access here.

Thank you very much. I see my time has expired.

Mr. BURR. Mr. Chairman.

Mr. HASTERT. The gentleman from North Carolina.

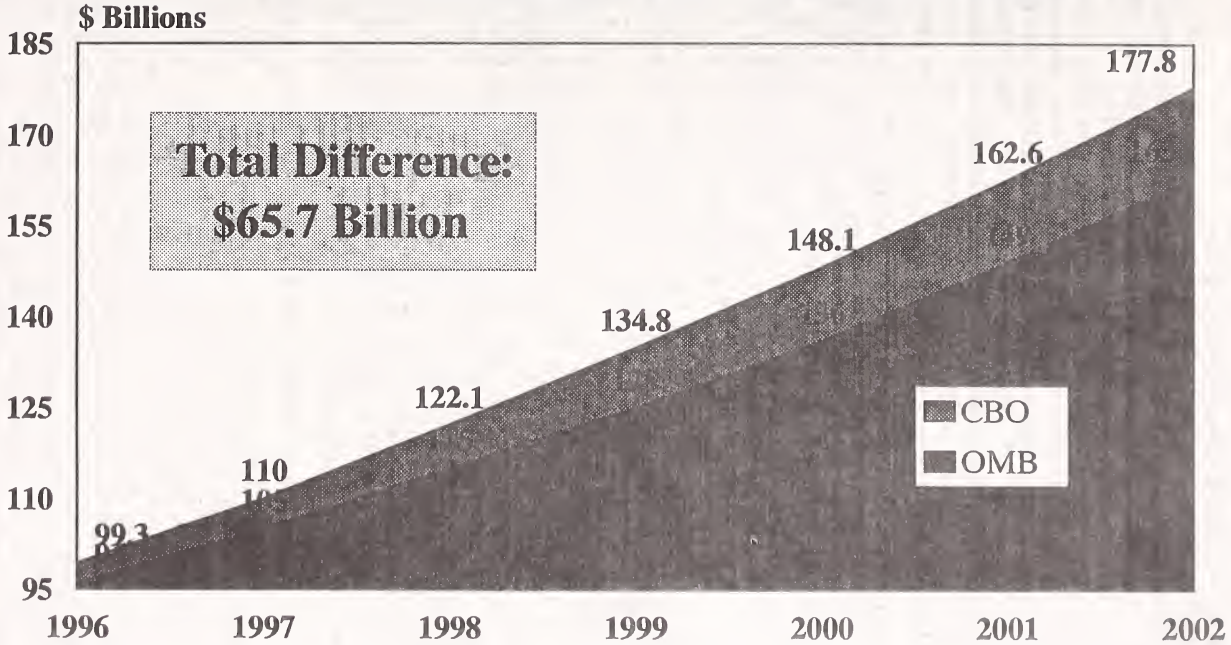
Mr. BURR. I would ask unanimous consent that I enter into the record the OMB's outlay numbers for Medicaid, along with the CBO baseline that we have matched it at. So the record does show, for Mr. Vladeck and those that read it, how I did come up with $121 billion number on the proposed cuts by the President.

Mr. HASTERT. Without objection.

[The chart follows:]

Medicaid Baseline Comparison: 1995-2002

CBO and OMB



Mr. HASTERT. This committee will recess until 1 p.m. The second panel will start promptly at 1 p.m.

[After Recess.]

Mr. BURR [presiding]. The subcommittee will come back to order. We're going to have a vote later and hopefully we can get through your testimonies prior to that vote taking place.

Michael McKinney, M.D., Commissioner, Department of Health and Human Services, from the State of Texas, welcome; Mr. Robert Corker, Commissioner, Department of Finance and Administration, from the State of Tennessee; Mr. Corker, welcome; and Ms. Jean Thorne, Director, Office of Medical Assistance Programs, Oregon Department of Human Resources, welcome.

Dr. McKinney, we will start with your testimony, if you please.

STATEMENTS OF MICHAEL D. McKINNEY, COMMISSIONER, DEPARTMENT OF HEALTH AND HUMAN SERVICES, TEXAS; BOB CORKER, COMMISSIONER, DEPARTMENT OF FINANCE AND ADMINISTRATION, TENNESSEE; AND JEAN I. THORNE, DIRECTOR, OFFICE OF MEDICAL ASSISTANCE PROGRAMS, OREGON DEPARTMENT OF HUMAN RESOURCES

Mr. MCKINNEY. First off, I appreciate the opportunity to appear before you. Governor Bush and the legislature of Texas have chosen to pursue an avenue that's been open to them by you all to pursue the 1115 waivers in regards to Medicaid.

We've gotten directions from them to figure out a way to integrate the systems that we have, and we have multiple systems, and a way to streamline them, to integrate them, to have only one system doing what we now have 3 or 4 different systems doing.

Part of the intent of this is to find out ways that we can consolidate funds that we're spending in different areas. Texas has a unique way of financing indigent health care. We spend a great deal of money, probably $1 billion in local funds that are not matched in Medicaid, that don't show up on any of the accounting. When they say how many State funds you spend and how many Federal dollars you spend in indigent health care, these won't show up.

We have hospital districts that are a taxing entity in the State of Texas and they have their own tax base. Then we also have a county indigent health care program. They spend, again, tax dollars, local tax dollars on Medicaid recipients or people who would be eligible if the Medicaid eligibility categories were raised.

So we're trying to find a way to put all these systems into one system, how to make it seamless for purposes of the client, for purposes of the providers, and, at the same time, abiding by Federal regulations on who we need to cover, who we have to cover, and, of course, on budget neutrality, we're dealing with that.

The whole program has been undertaken. The waiver will probably be submitted by August 31. So none of this has been completed. It is not in action, but it has an ideal, with an L, that we hope to achieve, that being to improve the access for these clients, for the patients, to improve their ability to have their own doctor. That's been a problem now. They go from one of these systems to another and there's a loss of continuity of care. If you lose the continuity of care, you have trouble proving that you're doing any

good, other than just spending the money and spinning your wheels.

So we're trying to put it under a single system, where we can prove outcomes, where we can prove that we are indeed providing care for those who are most in need of the care and that care that is needed doesn't go unprovided.

There has been a problem in the past that we're trying to get past, and that is a tie between the welfare system, the AFDC grants, cash grants, and our Medicaid system. In Texas, we really never have been very prone to cash grants, in all fairness. That's just philosophically not something that we've sought ways to increase. But every time that we've had an opportunity under the Federal program to take care of Medicaid needs, that is the medical needs, we've taken advantage of that.

When pregnant women went up to 133, when we were allowed to do that, we went to 185 percent of poverty. On children, any time we were allowed to add children to the program, we added children to the program. We covered elderly in nursing homes. We cover up to 200 percent of poverty. So the coupling of AFDC and cash grants and Medicaid is something we have tried to get away from in Texas.

Every chance we have to do Medicaid, we will, and every chance we have to do AFDC grants, we basically don't. That, again, is what this 1115 waiver does. It lets us expand medical coverage to take care of people who are in need of medical coverage without a tie to the welfare system. In fact, it's our contention that this is a way of encouraging people to have jobs and not lose insurance.

It's the idea that this will be a transition to get you away from dependence upon welfare so that you can have health care for your kids. That is really the meat of this whole program. I think that that philosophical difference between welfare and Medicaid will come up time and time again. It's one of the things that we've tried to maintain separately and by doing the local funds, we have done that really to the benefit of the Federal budget.

These are dollars that are matchable now and we've simply chosen not to match because we didn't want to involve ourselves in the welfare program.

This program should add at least 500,000 people to our Medicaid rolls, people that are getting care in this other system. It could be as many as another million people, to the 2.3 million that we already have on our Medicaid rolls. Again, it's an opportunity to increase the number of people, the number of Texans receiving Medicaid health care without increasing the number of Texans who are receiving cash grants. That's our approach to it.

We're also going to add a few things that are unique to this program. In addition to the funding source, which is the local tax dollars, we're also getting the local provider pools together. We're going to do a pilot on long-term care to try to figure out how we add Medicare, Medicaid, long-term care, community care all under a single umbrella in managed care, with an emphasis, again, on access and on quality of care, but to pick up all the long-term care.

We're also going to do a Medicaid savings account and we're going to figure out how we do that. We're going to do that as a pilot

first and we'll proceed with that based on HCFA's permission real soon, we hope.

Thank you, sir.

[The prepared statement and attachment of Michael D. McKinney follow:]

PREPARED STATEMENT OF DR. MICHAEL D. MCKINNEY, COMMISSIONER OF HEALTH AND HUMAN SERVICES, STATE OF TEXAS

Good morning. I am Dr. Mike McKinney, appointed by Governor George Bush as the Commissioner of Health and Human Services for the State of Texas.

Thank you for the opportunity to discuss the reforms Texas is undertaking in the Medicaid program. We are restructuring the program to emphasize better access, improved health outcomes, cost control and budget predictability for the billions of dollars we spend each year. We are pursuing an initiative to consolidate Medicaid with our local indigent health care programs in order to maximize the efficient use of the public funds available for health care, federal, state and local. Our initiative includes local options to design and run this restructured system, bringing health care decisions closer to the communities where patients, providers and taxpayers live, while maintaining a statewide standard for eligibility, benefits and quality outcomes.

This restructuring initiative is the result of legislation passed and signed into law this year which directs the Medicaid program to pursue waivers to accomplish these objectives. We are in the midst of finishing the design and, upon approval of the Governor and Legislative leadership, will submit our 1115 waiver request by August 31st.

THE CURRENT TEXAS MEDICAID PROGRAM

Texas has the third largest Medicaid program in the country: of our total population of 18 million, 2.5 million Texans received Medicaid last year, or one in seven Texans. Texas Medicaid cost $9.1 billion in FY 95, up from $3.3 billion in FY 90. It is budgeted at $9.75 billion for next year. The funding match is 62% federal, 38% state, and our federal match has been steadily declining over the past few years. Our spending on each recipient is among the more conservative levels among states, averaging $2,442 per recipient.

Estimates of Texas' anticipated growth rate for the next 5 years range from a low of 6.9% annual increase to high of 9% per year increase. At the low estimate, the program would cost $12.5 billion in FY 2000. Medicaid has grown as a share of the total state government to around 25% of total expenditures; it uses around 12% of the state's total general revenue funds each year.

Like most other states' programs, the vast numbers of patients in the Texas Medicaid program are children and their caretakers, approximately 2 million of the 2.5 million, or 80%. However, spending for this population accounts for only about 43% of the Medicaid program (without the Disproportionate Share funds). Conversely, the one in 5 recipients, or 20%, who are aged, blind or disabled account for 57% of the Medicaid program, due primarily to the cost of long term care services. Long term care services for nursing homes, community care and homes for persons with mental retardation comprise over 31% of the total Medicaid cost. The rest is spent on acute care services for aged, blind or disabled Texans.

The current Medicaid system is broken. Costs are unpredictable and keep rising faster than general inflation. In communities throughout the state we have difficulty finding providers who will care for the 2.5 million Medicaid patients. There is insufficient continuity of care and the development of physician-patient relationships which foster good health outcomes over time is extremely difficult because of this lack of participating providers. With problems like these, we have asked the question: what real *value* are we getting for the dollars we spend?

THE TEXAS INDIGENT HEALTH CARE SYSTEM

In addition to the federal-state Medicaid program, Texas supports extensive systems of locally funded health care for low-income persons who have no health coverage but do not qualify for Medicaid. The key factors in the growth of these two local systems, one primarily urban and one primarily rural, were the existing state constitutional requirements for indigent care and the state's reluctance to enhance the federally-directed cash welfare system. In other words, Texas did not and does not embrace the federal cash welfare system, which for most of the history of Medicaid dictated who could receive Medicaid health care assistance. This is an important

point you must consider as you design the new Medicaid program with flexibility for the states. Those states that historically kept their cash welfare programs low could not cover as many health care recipients as those states that had generous welfare programs.

Texas is a perfect example of this result: We have never supported a high welfare benefit for a single parent or two parent families with children. (It is currently $181 a month for a family of three with no income). We have never opted to provide supplemental welfare payments to SSI recipients, as many states do. Thus, our Medicaid eligibility, which has largely been tied to receipt of cash welfare payments, has remained relatively low compared with other states, even though our numbers of uninsured low income Texans are among the highest in the nation.

However, almost every time the federal government gave the states the option to expand health coverage through Medicaid *without* increasing cash welfare, Texas quickly moved to cover these populations. Throughout the 1980's, as children and pregnant women were made eligible by the federal government, Texas immediately chose to cover them with our Medicaid program.

In Texas, we have provided health care services to millions of low-income, mostly working, Texans who in other states would have been eligible for Medicaid. However, rather than cover these citizens with a program tied to higher welfare eligibility, we cover our people with local property tax funded programs through our local systems of urban hospital districts and rural county indigent health care programs. Eligibility for services currently ranges from 18% of poverty [about $2,266 for a family of three] to over 150% of poverty [about $18,885 for a family of three] in many urban areas. Our most conservative estimate is that over $1 billion in local funds, most of which comes from property taxes, are spent each year for local indigent health care services. The vast majority of persons receiving these services are in working families that do not have access to other forms of health insurance.

The key point is that in restructuring Medicaid for greater state responsibility and flexibility, you must not continue to hold states to the old cash welfare ties when it comes to allocating Medicaid funds among states. States must not be rewarded or punished in the new Medicaid block grants for the cash welfare AFDC decisions they made in the past. To do so is to perpetuate the disincentives of the welfare system, in direct contradiction of what we know about the importance of health care in helping families break free of the welfare system.

THE TEXAS 1115 WAIVER: RESTRUCTURING STATE AND LOCAL INDIGENT HEALTH CARE

Our goals for restructuring Medicaid are increased access to lower cost primary care services, improved quality of health outcomes resulting from our federal, state and local indigent health care systems, and cost containment and budget predictability. We are pursuing these goals by redesigning the Medicaid system to enhance local decision making and control of health care while encouraging private and public competition to hold down costs through managed care. Working together with local officials, as Medicaid never has before, we are restructuring health care financing and delivery systems from the local level up, allowing flexibility to shape service delivery systems to fit both the local or regional needs as well as the resources. In a state the size of Texas this is an ambitious task, but we believe that over the long run building local and regional systems is the best way to address the cost, fragmentation and quality issues we have been unable to address in our current systems.

Redesigning the delivery system is tied to restructuring our federal, state and local funding for Medicaid and indigent care. Again, our goal is to reduce the existing fragmentation and waste in the three separate systems which have developed through the years. By pooling our funds and being more efficient in how we buy health coverage, we can convert *existing* Medicaid disproportionate share dollars, local hospital district funds and county indigent health care dollars into health insurance for thousands of working uninsured Texans. The transition is complex and our numbers are not quite complete, but we believe the end result will allow additional health coverage for over half a million children and adults who currently have no access to health care except in hospital emergency rooms or public clinics. This is important, also, as a way to further break the tie to AFDC welfare, which many of these families see as the only alternative when they experience a major health crisis. It is important to understand that many of these Texans are people who have cycled between Medicaid and the locally funded services without the benefits of having the continuity of care from their *own* doctor. They also have the effect of costing the entire system more by using more expensive settings like hospital emergency rooms.

Central to Texas' restructuring of our fragmented systems is the implementation of managed care, which we have begun using 1915 waivers. We have had two managed care projects covering over 80,000 Medicaid recipients for the past two years, and the results are encouraging. Physician participation in these areas increased over 45% by using health maintenance organizations, primary care case management networks and prepaid health plan arrangements. We have seen savings of 4.2% overall, and we believe these are minimal compared with the potential savings we can attain in the increasingly competitive health care marketplace in Texas.

I want to emphasize that these savings are off our already comparatively low per person expenditures.

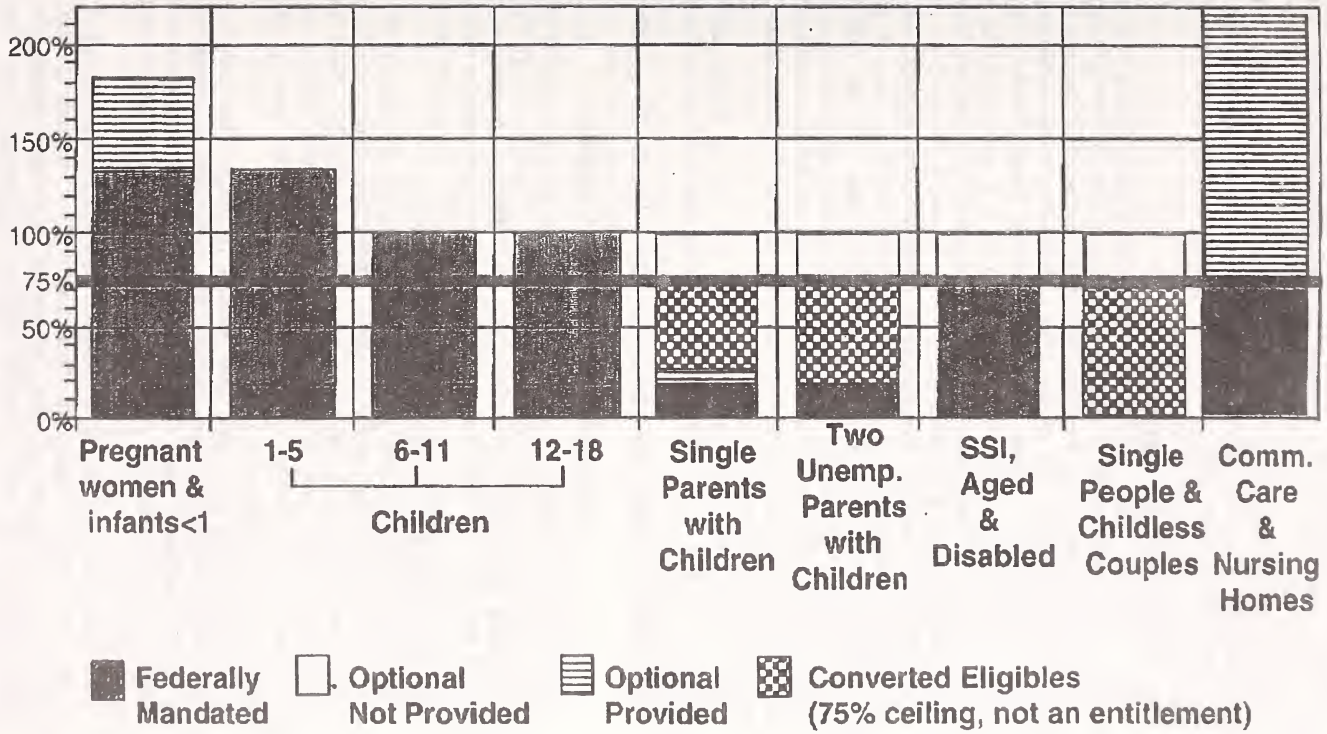
Equally important are the improvements, we have seen in the value we are getting in more appropriate use of services and basic preventive care. For example, use of the emergency room, which previously was often the only way Medicaid patients could get basic services, has decreased by almost 40 percent and the number of hospital days and length of stay have declined. More importantly, preventive measures such as immunizations for children and EPSDT screens have increased.

We are now in the process of developing three more managed care sites around Lubbock, Fort Worth and San Antonio. In addition to this initiative to restructure our acute care system, Texas is developing several demonstration projects that will test other important reforms of Medicaid. These include the concepts of a medical savings account for Medicaid recipients and a project to comprehensively integrate long term care services using Medicare and Medicaid. We are not as far along on these projects, but I mention them here as an indication of the state's interest and commitment to finding new solutions that will provide better services for less cost. These demonstrations will test whether or not these goals are met with these approaches.

In conclusion, Texas is facing many of the same issues you face in trying to control the Cost of Medicaid, while the growing demand for health care is draining our state and local coffers. We are trying to do so in a creative and responsible way, within the limits of available funds. We have looked at the entire indigent health care system in our state and are designing a new system that can, when fully implemented, more efficiently meet the needs of people who rely on our local and state system while minimizing the cost to taxpayers. We welcome your efforts to provide states' even greater flexibility through block grants, and we ask that in creating this new Medicaid system you correct the historical inequities and problems with the existing allocation formula for federal funds.

Thank you for this opportunity to tell you about Texas' plans, and I will be happy to try to answer any questions you may have.

Proposed Waiver: Eligibles



Mr. BURR. Thank you, Dr. McKinney. At this time, Mr. Corker, the Chair would like to recognize the gentleman from Texas, Mr. Barton.

Mr. BARTON. Thank you, Mr. Chairman. Very briefly. I apologize for being late to the afternoon session. I was supposed to have introduced Dr. Mike McKinney. I'm going to ask unanimous consent to do so at this point in time.

Mr. BURR. Without objection.

Mr. BARTON. Dr. McKinney has been appointed by Governor George Bush as the Director of the Texas Health and Human Services Commission, but I've known him since 1984 when I first got elected to the U.S. Congress. Dr. McKinney was a constituent of mine and was a State representative from Leon County and Centerville, Texas. He and his wife and my wife went to many political events on a bipartisan basis, since I'm a Republican and, at that time, he was a Democrat.

He probably still is a Democrat, but he was appointed by a Republican Governor. So he's an independent. But he's a good man. He's doing a good job for the State of Texas. He, in the past, has been a family practitioner. He's very personally committed to reforming Medicaid in Texas and working with this committee hopefully to let us show the way for the entire Nation about some of the reforms that we can use.

We appreciate his testimony and his being here personally. I apologize to the committee for not being here 10 minutes earlier to introduce him.

Mr. BURR. I thank the gentleman from Texas. Mr. Corker.

STATEMENT OF BOB CORKER

Mr. CORKER. Thank you, Mr. Chairman and members of the committee, for the opportunity to talk to you today about Tennessee's innovative approach to reshaping the Medicaid program, an approach that we in Tennessee believe can offer insight into the ways that the costs of providing indigent health care can be contained without sacrificing the quality of health care.

Tennessee legislators have great empathy for some of the decisions you're getting ready to make, because about 18 months ago, they were faced with some of the same decisions. And they made the decision that they could no longer afford the status quo, asking ourselves many of the questions that, frankly, you're going to be forced to answer during this debate.

Can our State and can the States manage the program dollars more effectively than the Federal Government and can health care be more affordable and still maintain the high quality of care that it must? I believe the answer to both of these questions is a resounding yes.

The decision we made to create TennCare was a right decision, there's no doubt about it. TennCare now operates the broadest health care program in the Nation, all provided through a market-based system. As with any $3 billion program, TennCare has not evolved without its growing pains. The results produced by TennCare do speak for themselves, however, and Tennessee has been able to expand its coverage for the working poor based on

some of the principles the gentleman beside me was talking about and to the uninsurable population.

We are close to universal coverage in Tennessee, with 95 percent of all Tennesseans having health care insurance today. This is something that personally I'm very proud of. I did not create this program. I'm very happy to have come behind those who did create it and I think it's a good concept. And I think most Tennesseans are very proud of the fact that we are covering another 400,000 uninsured because of the program we were able to implement.

In the first year of TennCare alone, Tennessee saved close to $1 billion of State and Federal moneys. The program growth rates were reduced from an average of about 15 to 22 percent a year to this last year of 1 percent. We've only been into the program about 18 months.

Very simply, we are able to serve 50 percent more Tennesseans with a large savings in Federal and State dollars by using this approach. TennCare is a philosophy that I very strongly believe in. It's built on the idea that Tennesseans should have access to affordable quality health care and that this access can be affordable also for the taxpayers. The existing TennCare system is only beginning and, believe me, if you go forward with some of the changes that you're discussing, and I hope you do, it's something you'll hear about probably more than any other issue that's dealt with in your respective States.

But by freeing up dollars to go with the enrollee, we have new networks and new systems that are being formed all the time to ensure portability for the poor, and I think that's a very significant change in the health care delivery system.

Health care executives, providers, advocates for the poor and community leaders are forced now to come together and focus on and help solve this problem. I'm certain that TennCare will evolve into a system that is far superior, far superior to the old Medicaid system, where we were locked into the status quo and we were definitely doomed to failure.

Mr. Chairman, I believe the best approach to dealing with the Medicaid program is to allow the States greater flexibility to design their own indigent care programs. The best means of accomplishing this flexibility is through a Medicaid block grant. I would encourage the members of this committee to listen to those who have been down at least a portion of the path and to support a Federal block grant proposal.

I would additionally ask that you take into account the great strides that waiver States like Tennessee have made, Oregon and others, and help ensure that we are not penalized for addressing the spiraling problems of growth rates while, at the same time, offering health care to those who were previously uninsured. Pioneers like Tennessee and others should be rewarded for the fiscal and social responsibility they have shown.

Finally, Mr. Chairman and members of the committee, as the spokesman of the only budget-neutral 1115 waiver existing today, I believe that Tennessee has much experience to offer the Nation in this debate. We are aware of the many opportunities and pitfalls that other States will face and, believe me, we face new ones each

day. I'm sure one has cropped up today that I'm unaware of. Tennessee is ready to help, though, in any way possible.

I thank you very much for this opportunity to participate today. We look forward to working with you as this complex issue develops over the next few months. I'll be glad to answer any questions later. Thank you.

[The prepared statement of Bob Corker follows:]

PREPARED STATEMENT OF BOB CORKER, COMMISSIONER, DEPARTMENT OF FINANCE AND REVENUE, STATE OF TENNESSEE

Mr. Chairman, members of the Committee, thank you for giving me the opportunity to talk with you today about Tennessee's innovative approach to reshaping the Medicaid program, an approach that we in Tennessee believe can offer insight into ways that the cost of providing indigent health care can be contained without sacrificing the quality of that health care.

Tennessee legislators have great empathy for those of you on this Committee. You are faced with the same difficult decisions that Tennessee was faced with some 18 months ago. Tennessee made the decision that we could no longer afford the status quo asking ourselves many of the questions you will be forced to answer during this debate—Can the states manage the program dollars more effectively than the federal government? Can healthcare be made more affordable and still maintain the high level of quality that is a must? I believe the answer to both of these questions is a resounding yes.

The decision we made to create TennCare was the right decision. Tennessee now operates the broadest health care program in the nation—all provided through a market-based system.

As with any $3 billion program, TennCare has not evolved without its growing pains. However, the results produced by TennCare speak for themselves. Tennessee has been able to expand its coverage to the working poor and to the uninsurable population. We are close to universal coverage with approximately 95% of all Tennesseans having health care insurance today. *This is something I am very proud of, and I think most Tennesseans are proud of.*

In the first year of TennCare alone, Tennessee saved close to $1 billion of state and federal dollars. The program's growth rates were reduced from an average annual increase of 15-22% to less than 1%. Very simply, we were able to serve 50% more Tennesseans with a large savings in federal and state dollars.

TennCare is a philosophy as much as it is a government program, and it is a philosophy that I believe in very strongly. It is built on the idea that Tennesseans should have access to affordable, quality health care, and that this access can be affordable, also, for the taxpayers.

The existing TennCare system is only a beginning. By freeing the dollars up to go with the enrollee, new networks and systems are being formed to ensure portability for the poor. Health care executives, providers, advocates for the poor and community leaders are forced to come together to focus on and help solve this problem. I am certain TennCare will evolve into a system far superior to the old Medicaid system where we were locked into the status quo, doomed to continued failure to capture innovation and the inability to care for more citizens with delivery resources.

Mr. Chairman, I believe that the best approach to dealing with the Medicaid program is to allow the states greater flexibility to design their own indigent care programs. The best means of accomplishing this flexibility is through a Medicaid block grant. I would encourage the members of this Committee to listen to those who have been down at least a portion of the path, and to support a federal block grant proposal.

I would additionally ask that you take into account the great strides that waiver states like Tennessee have made, and help ensure that we are not penalized for addressing the spiraling problems of growth rates while at the same time offering health care to those previously uninsured. Pioneers like Tennessee should be rewarded for the fiscal and social responsibility they have shown.

Finally Mr. Chairman and members of the Committee, as the spokesman of the only budget neutral 1115 waiver existing today, I believe that Tennessee has much experience to offer the nation in this debate. We are aware of the many opportunities and pitfalls that other states will face. Obviously—we face new ones each day ourselves. Tennessee is ready to help in any way possible.

Mr. BURR. Thank you, Mr. Corker. The Chair would now recognize Mr. Wyden from Oregon.

Mr. WYDEN. Thank you very much, Mr. Chairman. I think the subcommittee is particularly fortunate today to have a friend of mine, Ms. Jean Thorne, who runs Oregon's exceptionally creative and innovative Medicaid program.

Oregon has really been involved in two landmark areas with respect to Medicaid. First, our services for the elderly are regarded as state-of-the-art in terms of in-home services and then a lot of us feel that the Oregon Health Plan is essentially the first of its kind in our country to have to come to grips with the priorities and the tough choices that you face in health care.

We try to make sure that all our citizens are covered. I would hope that all of our colleagues listen carefully to Ms. Thorne because Ms. Thorne raises some very serious questions about whether a program like Oregon's can survive under the legislation that was adopted in the House with respect to the budget. We don't want to ding the good States, the States that really are state-of-the-art in terms of providing us innovative approaches from the field.

I know my colleague from Florida, Mr. Stearns, is part also of an innovative program, and I just don't want to see those good States get dinged. I thank you, Mr. Chairman, for the chance to introduce Ms. Thorne.

Mr. BURR. I thank the gentleman from Oregon and would exercise the option of the Chair to say what we'd like to do is replicate those good things around this country. With that, Ms. Thorne.

STATEMENT OF JEAN I. THORNE

Ms. THORNE. Thank you, Mr. Chairman. I appreciate having the opportunity to talk with you today about what we have accomplished in Oregon under our 1115 waiver and also concerns we have about how block grants might impact both reform we've undertaken and that other States may wish to undertake.

As you may know, Oregon was the first State in this decade to receive a section 1115 waiver to undertake statewide Medicaid reform. Earlier, I thought that was Oregon's stack of waiver documents. It's Illinois, but I think ours is probably higher than that. We went through a very long arduous process. We did go through two different administrations. We were here before this subcommittee. We had bipartisan support and bipartisan opposition to what we were doing. But, finally, in March 1993, we received waiver approval.

The Oregon Health Plan reforms the Medicaid program in Oregon basically four ways. We expand eligibility to cover almost all Oregonians with income under the Federal poverty level. The benefits are based on the infamous priority list of health services, which has actually been the part that's been most controversial, at least back here. We deliver services, to the extent possible, through prepaid plans. And, last, we reimburse for services to those plans at a rate to try to cover the costs of providing services in the managed care environment.

The first phase of the health plan began just about 18 months ago. At that point, we took most existing Medicaid clients, brought

them in under the Oregon Health Plan, meaning the benefit package in managed care. We also opened it up to the other new eligibles, those with income under the Federal poverty level.

The second phase began in January of this year, where we took remaining Medicaid clients, namely, primarily the SSI population, and brought them in under the Oregon Health Plan. By all accounts, we seem to have been pretty successful. We now have almost 130,000 new enrollees, new eligibles in the Oregon Health Plan. That's about a 50 percent increase in our traditional Medicaid population.

To our surprise, up to two-thirds of the people coming in as new eligibles are families with a child in the household—very different from what we thought we would find. It was very clear that health care coverage is very important to poor working families.

We've been pleased also with the participation in managed care both from providers and from clients. We had 85,000 Medicaid clients in managed care the month before the health plan started. We now have almost 300,000; 77 percent of the Medicaid clients in Oregon are now in managed care. We have sufficient capacity to mandate enrollment in almost all areas of the State, including very rural and frontier Oregon.

I think another important aspect has been the indirect impacts the health plan has had on the business community. The Oregon Hospital Association has found that in the first 12 months of the Oregon Health Plan, charity care has dropped by over 30 percent. Now, this means that businesses and other private payers who have had to pick up that cost shift in the past no longer have to do that.

So we're proud of what we've done in Oregon, but we're also very concerned with the implications of potential block grants and our ability to continue carrying out this program. Obviously, we're a supporter of increased flexibility. We would not have gone through what we had to go through if we didn't feel that we could put together a good program. Block grants would obviously give us that amount of flexibility without having to go through very complicated processes, although from looking at the stack, I think it probably contributes to the timber economy in Oregon.

But beyond that, we have some concerns. The funding levels are obviously a very real area of concern for us. Our growth in the Medicaid budget in the last 2 years has averaged 18 percent. Over the next 4 years, we expect it to average 10 percent. Even if we are able to continue our section 1115 waiver with the funding initially anticipated, the question is what happens at the end of our 5 years of demonstration.

Second, we have concerns about the interrelationship of the Medicaid block grants with other proposed block grants. Clearly, as we have seen how health care is very important to poor working families, if we really want to move people off of welfare, it's important that we recognize the areas like health care and child care are very important supports to help that happen.

So as we reform our welfare system, we need to recognize that these other areas of potential block grants could impact our ability to actually help people become self-sufficient.

Last, I'd like to speak to the need for continuing Federal partnerships in Medicaid. It's tempting to say give us the money and leave us alone. On the other hand, we believe the Federal Government should continue to have some measure of accountability and, also, that they should hold States accountable to carry out some of the basic premises.

We have concerns that as we have done welfare and health care reform, we do not want to become a magnet for poor persons from other States. We also believe, as Governor Symington said this morning, that we need to look at issues such as growth rates in various States that may be different and that the Federal Government should continue to have some measure of fiscal accountability.

In summary, in Oregon, we're proud of what we've been able to do in reforming and expanding our Medicaid program. We support the flexibility that block grants would give us, but we believe it's unrealistic to expect that these kinds of meaningful reforms could be carried out under the funding constraints currently being considered.

[The prepared statement of Jean I. Thorne follows:]

PREPARED STATEMENT OF JEAN I. THORNE, DIRECTOR, OFFICE OF MEDICAL ASSISTANCE PROGRAMS, OREGON DEPARTMENT OF HUMAN RESOURCES

Mr. Chairman, I am Jean Thorne, director of the Medicaid program for the State of Oregon. I appreciate the opportunity to speak with the committee on our experiences as a state which has undertaken major Medicaid reform under a Section 1115 waiver and how block grants might impact such reforms.

As you may know, Oregon was the first state in this decade to receive approval for a Section 1115 waiver allowing for statewide reform of its Medicaid program. The quest for our waiver was a very long one, spanning two different Administrations as well as an appearance before this subcommittee. Oregon began to discuss the need for health care reform in the late 1980's, long before the discussion became a national one. A major component of our health care plan was the reform and expansion of our state's Medicaid program. We ultimately received approval of our waiver request in March of 1993.

Medicaid reform under the Oregon Health Plan (OHP) has four primary components:

Eligibility—Those receiving coverage are people with family income under the Federal Poverty Level (as well as pregnant women and children under six to 133%).

Benefits—The benefit package is based on a prioritized list of health services wherein the state Legislature determines the package by "drawing the line" on the prioritized list.

Delivery systems—For most clients under the OHP, services are delivered through fully-capitated prepaid health plans.

Reimbursement—The capitation rates paid to managed care plans are based on the reasonable costs of providing the covered services in a managed care environment.

The first phase of the OHP began February 1, 1994. At that time, people who were previously eligible for Medicaid because they were on AFDC or poverty level pregnant women or children began receiving their coverage based on the prioritized list, as well as being aggressively moved into managed care plans. Other persons previously not covered by Medicaid, but with incomes under the poverty level ("new eligibles") also began enrolling in the OHP. The second phase of the OHP began January 1, 1995. At that time, the remaining Medicaid eligibles, namely the SSI population and children in foster care, transitioned to the OHP. Oregon also began the phase-in of chemical dependency and mental health coverage as part of the prioritized list and managed care.

By all accounts, Medicaid reform under the OHP has been successful.

- We currently have almost 130,000 new eligibles enrolled in the OHP (this is in addition to our "traditional" Medicaid population of over 260,000). To our surprise, the characteristics of these new enrollees were not what had been ex-

pected. Our original planning had assumed that most new enrollees would be people without children, those who, no matter how poor, would not have qualified for traditional Medicaid. In fact, up to ⅔ of new enrollees have a child in the household. And of those households, most have two parents. In addition, the largest single group of enrollees without children are women aged 51-64, women who are too young for Medicare but no longer able to qualify for AFDC and Medicaid. It is clear that the OHP has become a critical support for low income Oregonians who might otherwise have to resort to welfare to provide for their medical care.

- The participation in managed care has far-surpassed our initial hopes. In the month prior to OHP start-up, 85,000 Medicaid clients were enrolled in prepaid plans. As of this month, almost 300,000 are enrolled. The transition to managed care has been a relatively smooth one. The planning process for this delivery system was an inclusive one. The response from plans prior to implementation was enthusiastic; we were able to have sufficient capacity to mandate enrollment in almost all areas of the state, even in extremely rural Oregon.
- There have been indirect impacts on other payers because of the reduction in uncompensated care. The hospitals in Oregon have compared data for the 12 months immediately prior to OHP with the first 12 months of the OHP and have found over a 30% reduction in charity care. By providing coverage to more low-income Oregonians and reimbursing for services at reasonable rates for all Medicaid clients, this program will also benefit businesses and other private payers who formerly absorbed that cost-shift.

We are proud of our success with the OHP, but are concerned with the potential impacts that Medicaid block grants might have on this program and others like it.

Obvicusly Oregon is a supporter of increased flexibility. The long, arduous trip we made to secure our waivers was testimony to our belief that we could provide a better program if we had the flexibility to design it our own way. Block grants would give us that flexibility without the necessity of going through the type of process which required such enormous amounts of time, energy and money to develop and secure a waiver.

However, the discussions occurring around funding levels would make the ability to carry out a reform such as the OHP highly unlikely. Over the past 2 years, our growth in Medicaid has averaged 18% per year. We estimate that our growth over the next 4 years will average 10% per year. Obviously, given the level of caps being discussed, being able to sustain this highly successful reform is questionable. Even if there are provisions to allow those states which have secured waivers to continue them with the funding initially assumed, what will happen after our five years have ended? Will we only be delaying the inevitable?

Secondly, there are concerns about the interrelationship of possible Medicaid block grants with other potential block grants. Given the desire to reform our welfare system, we should acknowledge that persons do not stay off of welfare or move out of welfare without some types of supports. The fact that almost ⅔ of our new eligibles are families with children speaks to the importance that health care coverage plays to poor working families. Child care is also critical to their ability to become self-sufficient. How can we provide these supports to achieve the goals of self-sufficiency if they, too, are being reduced through block grants?

Lastly, I would like to speak to the need for continuing federal partnerships in Medicaid and other block grants. Although it is tempting as a state to ask you to just give us the money and leave us alone we in Oregon believe that the federal government should continue to be accountable and to hold states accountable for providing health care to low-income persons. As states, we have all complained of the micromanagement contained in federal laws and rules. We support flexibility to allow us to achieve our goals. But it is critical that there be some federal framework which would assure that these federal funds are in fact being used to achieve these goals of basic health care coverage for low-income Americans. Not only do we make these comments based on a concern for governmental accountability, we also are concerned that the absence of some federal framework might cause further hardships to states such as Oregon. In Oregon, we have undertaken successful programs in the areas of health care and welfare reform. In the absence of standards for accountability, we are concerned that Oregon could become a magnet for poor persons from other states.

In addition, the federal government should continue to assume shared responsibility for dealing with increased population and unforeseen economic circumstances and not merely abdicate the tough choices to the states. For instance, Oregon projects an increase in population of 16% in the next 10 years, yet the proposals being discussed do not appear to account for such growth.

In Oregon, we are proud of the work we have done in reforming and expanding our Medicaid program. We support the flexibility that would be given by block grants, but believe it is unrealistic to expect that these kinds of meaningful reforms could be carried out under the funding constraints currently being discussed.

Mr. BURR. The Chair thanks you, Ms. Thorne. The Chair would take the opportunity to recognize himself at this time.

Mr. Corker, if I understood you correctly, Tennessee saved $1 billion in the first year and had an increase of 50 percent in residents that were covered.

Mr. CORKER. That's correct, sir.

Mr. BURR. How did you accomplish that?

Mr. CORKER. By moving to 12 market-based managed care organizations, where we paid capitation rates to cover the care of citizens. We were able to take and pool together the funds to cover another 400,000 Tennesseans. We have been criticized, to some degree, for paying low capitation rates and we have made adjustments in this year's budget still well below the Federal cap that we have in the 1115 waiver to make up for some of those differences.

Another way of approaching adding the 400,000 Tennesseans that we added, the 50 percent more that we added with no additional cost, would have been to add 100,000, 200,000 a year gradually over time as efficiencies in the system occurred. But no doubt due to the dramatic change that we put in place in 1994, health care systems are having to come together to create partnerships like they've never done before in Tennessee.

I believe the approach that we've used by moving it out to 12 private-based systems based on market, we're going to continue to see efficiencies grow. The other thing that's a great asset to the State of Tennessee as we look forward to welfare reform, as Ms. Thorne has pointed out, one of the great fallacies of Medicaid is that once people make a certain dollar amount of income, they lose all health care benefits. But under TennCare, they start paying based on ability to pay.

So there's been a huge boom to the State. As I travel around the State talking to people on various talk shows, work groups, whatever, we continue to have Tennesseans more and more that want to be a part of TennCare and we're trying to do what we can to start causing citizens to pay more premiums based on ability to pay to allow even more Tennesseans to come on the roll.

Mr. BURR. You have a program that is highly touted in Washington.

Mr. CORKER. Good.

Mr. BURR. So does Ms. Thorne.

Mr. CORKER. Right.

Mr. BURR. And I guess let me turn to Ms. Thorne, if I could. What's different about Oregon? And when I say touted, not just by your members. I think all of us recognize that your States have come up with creative ways to address a problem to the States and to the Federal Government. That's, in fact, what this committee is dealing with, how we can help stimulate that creativity in all 50 States and what type of flexibility is needed.

So, Ms. Thorne, can you comment on the difference, I guess, between a State, in Tennessee's case, that injected managed care,

grew the population covered, found a savings, versus where you are in Oregon on that program?

Ms. THORNE. I think, Mr. Chair, and I'm not an expert on Tennessee, we did start with somewhat different places. I think Tennessee is a high disproportionate share State perhaps. There has been quite a bit of money put into disproportionate share. We are very low DSH State, 2.2 percent, and so we are starting from somewhat different positions in terms of ability to garner savings.

In terms of the flexibility and the desire to do that, we started back in the late 1980's discussing the need to reform our health care system and that Medicaid should be part of that. But each State is very different. And I know I heard a few months ago, as I was at a meeting of various States, it wasn't Medicaid people, it was human service people saying when we get to Medicaid, it's going to be every State for themselves, because every State is starting from a very different point in terms of what their past practice has been either in funding or in programs.

Mr. BURR. Are there some States, Ms. Thorne, that just couldn't tackle that? I mean, you looked over, and I wish I'd have had a picture of the expression on your face. It was like let me never see that again. I think your first expression was I think ours was worse than that.

Ms. THORNE. I believe ours probably was. I heard a lot of criticisms of HCFA this morning and I would just like to State HCFA was not an impediment for us. I think for us, it was much more of a political discussion and the issues around Oregon trying to get waiver approval were higher than HCFA.

But I think that there were many other things that HCFA required of us that, as good managers, we should be expected to do anyway. It made it easier for us, in some cases, to say to our health plans, from the very beginning, you're going to provide encounter data to us. Now that we have encounter data, that will give us an ability to better measure what we are doing.

And with this kind of investment that we're making with State dollars, also, our State policymakers want to know what we're doing. There are States that can't tackle that. I think that it is a costly process, it is a time-consuming process. But in some cases, I think HCFA has asked good questions to make sure States are really ready. We've had a couple of instances where we made a decision to delay something a couple months and HCFA said they were very glad we did because they would have recommended that.

Different States are in different positions. We took a lot of time to do planning. A lot of that time wasn't especially self-imposed time. It was time that we sat around waiting for our waivers to come through, but I think it made for a very smooth transition, and we've had a smooth implementation of our health plan.

Mr. BURR. Let me say that those of us who serve are not always as quick to acknowledge good deeds as we've looked at HCFA, I have personally been guilty of that, as well. But let me say, also, I think that the challenge that we face is to stimulate the same creativity that we see displayed in Oregon, in Tennessee, hopefully as you move toward your waiver process; Dr. McKinney in Texas, the same type of thing, and how we can either replicate that from

a Federal agency-driven program or, in the case of the block grants, to allow each individual State to meet the individual needs.

My time is up, but let me say that in the first panel, many people suggested that every State was different, that they are starting at different levels, and that to think that we can have one agency or one individual or one committee of Congress that sets out one set of guidelines, that says here are the rules, that, in fact, they're not going to apply the same to all 50 States.

And where we may be successful in 10, we may be unsuccessful in 40. And the attempt and the challenge here for the members of this committee is to be successful in 50.

The Chair would recognize the ranking minority member, Mr. Waxman.

Mr. WAXMAN. I thank the chairman and would yield to Mr. Wyden.

Mr. WYDEN. I thank you, Mr. Chairman. I thank my friend from California, as well. Your bouquets for Oregon and Tennessee and Texas are all very much appreciated. I think what troubles this member is that I am convinced that the state-of-the-art programs we're hearing from are going to have great difficulty surviving with these draconian budget cuts that are being conceived by the majority.

I think it's especially unfortunate because I think all of us on both sides of the aisle want to encourage innovative work at the State level. I look at what's being done on Medicare and Medicaid in particular and in a State like Oregon, where we have driven down the costs, folks who have already gotten thin, it seems to me, are going to starve under these kinds of budget cuts.

I guess what I'd like to ask you to begin with, Ms. Thorne, is tell us what you would envisage based on the formula you now know. And, obviously, there are myriad details to be worked out, but based on what you now know, what kind of benefits are likely to be lost and what kind of people are likely to lose them?

Ms. THORNE. It's very hard to know, and the reason I say that is because when I look at what we've done in Oregon, we've done those big things that save money, we've done managed care. Our long-term care program, I was picking up some statistics last night, we have less people in nursing homes today than we did 10 years ago, although our population age 75-plus has grown by 40 percent.

We have 20,000 in home and community-based care and only 7,500 in nursing homes. So we have done that. I think we're probably further out than any other State. We've done managed care. It's hard to see where we would go next. I'm very concerned with the Oregon Health Plan. I do not want to say the Oregon Health Plan or our Medicaid expansion will go away, but I do think we'll have to seriously look at that—can we afford that additional 130,000 people if we have to look at the kinds of cuts that we may be facing.

And if we can't, what are the ramifications on our other systems? What are the ramifications on helping people move out of welfare? What are the ramifications on the cost shift? The kinds of accomplishments we have made I am concerned that we will have to retrench from. I'm not ready to say we will, but I think we'll have to seriously look at that.

Mr. WYDEN. Why don't you, for the record, furnish us what your best sense is today of what you would have to do if you had to start limiting access, because as I look at it, the poorest, most vulnerable people in Oregon, a State that has already driven down the costs, are either going to lose some of those benefits or they're going to be lopped off the rolls all together.

I think it's especially unfortunate at a time when people in both political parties believe we ought to be encouraging innovation at the State level. It's the innovative States who give us the chance to have a model for the rest of the country who are likely to get flattened.

Mr. Chairman, I just have a housekeeping matter that the minority wants to deal with. There was a witness on the last panel, a Mr. Condon, who made some fairly serious charges with respect to a program involving crack babies. I think it's the view of the minority that Mr. Condon, who is a defendant in one of the cases involving this program in the U.S. District Court in South Carolina, may have some motives with respect to his views on the program.

I would just ask unanimous consent, for the record, that several documents pertinent to this case that the minority has be entered into the record at this point.

Mr. BURR. Without objection.

[The documents referred to follow:]

THE CENTER FOR REPRODUCTIVE LAW & POLICY,
New York, NY, July 24, 1995.

Sharon Herald

To the Editor:

I am writing to respond to your blatantly inaccurate and inflammatory editorial entitled, "Dept. of Health and Human Disservices" (July 1). Although I respect and share your concern for the health and well-being of children, the program adopted by the Medical University of South Carolina (MUSC) can hardly be touted as a model to achieve this honorable goal.

Let's be clear about that program. Under the policy, as initially implemented, pregnant women who tested positive for cocaine were arrested—without ever being offered substance abuse treatment—and taken to jail, where neither prenatal care nor treatment is available. At least one woman who was jailed while pregnant was handcuffed to her bed during labor and delivery; another woman had her legs shackled to the bed so that she could not go to the bathroom without permission. While MUSC claims that this program "worked," alleging that the numbers of drug-exposed infants decreased, experts in research on human subjects are clear that the hospital's study was so sloppy that it cannot support this conclusion. Meanwhile, other MUSC research indicates that the policy in fact deterred women from seeking the very prenatal care that could advance their children's health.

In October 1993, the Center for Reproductive Law and Policy filed suit against the MUSC policy for a simple, compelling reason: doctors and nurses should serve the health care needs of their patients, not act as agents of the police. Each of us who visits a hospital, clinic, or doctor's office does so because we need medical care. We trust that the conversations we have and the information we give will be used solely for our appropriate medical care, not turned over to the police without our knowledge or consent. This principle cannot be abandoned for anyone, especially not for a pregnant woman who may have an addiction problem. In your haste to dismiss these important issues, your editorial falsely states that a federal judge has dismissed our suit. In fact, the case continues and we are confident of success.

Even more important, every major medical and public health group in the country—ranging from the American Medical Association and the American Academy of Pediatrics to the March of Dimes—agrees that threatening pregnant women with arrest deters them from seeking the prenatal care that can ensure the good health of their future children. These organizations—many of which have an explicit mandate to *protect* children—have taken public positions *against* policies such as that implemented by MUSC.

Finally, your condemnation of the U.S. Department of Health and Human Services clearly misstates that agency's action—HHS's Office for Protection from Research Risks indicated that the policy "raise[d] serious concerns about the adequacy of MUSC's institutional system of protections for human subjects." The hospital heard from the research-related arm of HHS *nearly a month after* it had ended the policy by consent decree in order to stave off an additional inquiry by the agency's Office of Civil Rights, whose preliminary investigation indicated that the hospital may have violated the federal Civil Rights Act. Given our nation's long tradition of protecting victims of racial discrimination in federal courts and administrative proceedings, the fact that the Office of Civil Rights took action to stop flagrant discrimination ought to be applauded, not criticized.

Health care providers and local officials who are truly committed to promoting the health of pregnant women and children should ensure that medical and public health expertise, not politics and blame, dictate their policy decisions. It is good maternal nutrition, prenatal care, and drug treatment programs—not punitive policies—that will help us eliminate health problems at birth and behavioral and learning disorders later in life.

KATHRYN KOLBERT,
Vice President.

DEPARTMENT OF HEALTH & HUMAN SERVICES,
September 30, 1994.

Dr. James B. Edwards
President
Medical University of South Carolina
171 Ashley Avenue
Charleston, SC 29495

RE: Human Subject Protections Under Multiple Project Assurance M-1012

Dear Dr. Edwards: The Office for Protection from Research Risks (OPRR) has reviewed the involvement of the Medical University of South Carolina (MUSC) in the "Charleston Interagency Policy on Cocaine Abuse During Pregnancy."

Based on materials provided by the MUSC and by the complainant, OPRR has determined that certain activities related to this involvement constitute research involving human subjects, as defined under Health and Human Services (HHS) regulations at 45 CFR 46.102(d) and 46.102(f).

(1) OPRR finds that the report authored by MUSC personnel and published in The Journal of the South Carolina Medical Association (Horger, Brown, & Condon, 1990, 527-531) at a minimum reflected retrospective human subjects research. It is OPRR's determination that this research should have been submitted to the MUSC Institutional Review Board (IRB) for prior review and approval. OPRR notes that the activity does not qualify for exemption under 45 CFR 46.101(b).

(2) The authors characterized the above referenced report as "preliminary" and announced their intention to report further "after 12 months' data collection" (Horger et al, 1990, page 531). OPRR finds that, from the time at which the authors formed this intention, the activity constituted prospective human subjects research. It is OPRR's determination that this research should have been submitted to the MUSC IRB for prior review and approval.

OPRR finds that the above referenced failure by MUSC personnel to submit human subjects research activities for IRB review constituted serious failure to comply with the requirements of HHS regulations at 45 CFR 46.109(a) under terms of the MUSC Multiple Project Assurance (MPA No. M-1012 at Sections I.B.2 and I.G.2.

This noncompliance raises serious concerns about the adequacy of MUSC's institutional system of protections for human subjects under its MPA. Consequently, OPRR has determined that it will defer consideration of the scheduled renewal of the MUSC MPA for a period of at least one year. During this period, the current MPA may be administratively extended by OPRR, subject to the following restriction:

> MUSC is hereby required to develop and implement a program of corrective actions to ensure (a) that any continuation of the Interagency Policy, as modified in accordance with the September 8, 1994 Settlement Agreement between the MUSC and the HHS Office for Civil Rights, receives appropriate IRB review and approval; (b) that all members of the research community fully understand their obligations under the HHS human subjects regulations and the MUSC MPA; (c) that all IRB members receive both initial instruction and periodic continuing education in human subject protec-

tion requirements; (d) that mechanisms are established for identifying prospectively any activities which constitute human subjects research; and (e) that all human subjects research conducted by MUSC personnel receives prior IRB review and approval.

To facilitate development of this program, OPRR will conduct a technical assistance site visit during which MUSC representatives can present and discuss their proposals for satisfying the required corrective actions. Beginning 30 days after the site visit takes place, the MUSC must provide OPRR with Quarterly Progress Reports documenting implementation of such actions. Extension of the current MPA shall be contingent upon OPRR's determination that corrective actions are proceeding satisfactorily.

OPRR wishes to emphasize its commitment to cooperative interaction with the MUSC in its efforts to enhance institutional human subject protections. Please contact me by October 17 to confirm the date and agenda for OPRR's visit (see enclosure).

Sincerely,

J. THOMAS PUGLISI, PH.D.,
Chief, Compliance Oversight Branch,
Division of Human Subject Protections.

Enclosure

cc: Dr. Edward C. Conradi, MUSC
Dr. Rosalie K. Crouch, MUSC
Dr. Gary Ellis, OPRR
Dr. Melody Lin, OPRR
Mr. Robert Lanman, OGC
Ms. Abigail Cummings, OGC
Mr. Dennis Hayashi, OCR
Mr. Paul Goebel, FDA

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF SOUTH CAROLINA
CHARLESTON DIVISION

Crystal M. Ferguson, Theresa Joseph Darlene M. Nicholson, Paula S. Hale, Ellen L. Knight, and Patricia R. Williams on behalf of themselves and a class of women similarly situated Plaintiffs, v. The City of Charleston, South Carolina, Dr. Harrison L. Peoples, Dr. Thomas C. Rowland, Jr., Dr. Stanley C. Baker, Jr., Dr. Charles B. Hanna, Dr. Cotesworth P. Fishburne, Dr. E. Conyers O'Bryan, Melvyn Berlinsky, Patricia T. Smith, M. J. Cooper, Herbert C. Granger, Robert C. Lake, Jr., Phillip D. Sasser, Claudia W. Peoples, Dr. Carroll V. Bing, Jr., Reuben Greenberg, Charles Molony Condon, David Schwacke, Shirley Brown, R.N., Edgar O. Horger, III, M.D., Victor Del Bene, John Sanders, William B. Pittard, M.D., Roger Newman, M.D., Harold Bivins, M.D., Melesia Henry, R.N., Defendants.	C/A No. 2:93-2624-2

DECLARATION of Lori Griffin

LORI GRIFFIN, being duly sworn, deposes and says:

1. I am an African-American woman living in Awendaw, South Carolina.

2. In early 1989, when I was about three months pregnant, I began regular visits to the St. James Santee clinic in McClellanville, South Carolina. At about four or five months, they referred me to the Medical University Hospital because they said I was "high risk." They said it was because I had high blood pressure, and my second child was born prematurely. I started going to regular appointments at the Medical University. I don't

remember anyone ever saying anything to me about substance abuse during pregnancy, or asking me to sign any special consent forms. I was not aware of any policy about arresting women who abused substances during pregnancy.

3. Not too long after Hurricane Hugo, in late September or early October 1989, I began experiencing premature labor pains. At that time I was about seven or eight months along in my pregnancy. I went to Medical University, where I was admitted. I was given drugs to control the premature labor pains, and was told I would have to stay overnight.

4. The next day, Nurse Shirley Brown came into my room. I had never met her before. She told me that I was going home soon. Then she began asking me various questions like most social workers. When she asked about any problems I might have, I confided in her that I had a problem with drug use. She told me to get dressed, and left the room.

5. The next time the door opened, it was a couple of police officers, in uniform, telling me that I was under arrest, and reading me my rights. I was totally shocked, and didn't understand why I was being arrested.

6. The officers put handcuffs on me, and had me sit in a wheelchair. One officer put his jacket over my hands to hide the handcuffs, but then I was wheeled out through the hospital with several officers in uniform. Everyone we passed was staring at me -- this pregnant woman being escorted out of the hospital by all these officers. I wasn't allowed to make any phone calls, and

didn't know what I was being arrested for. I was taken to the county jail and kept in a holding cell until my bond hearing later that day.

7. At my bond hearing, I finally found out that I was arrested for distributing drugs to a minor. Even though it was my first arrest ever, the judge refused to release me on my own recognizance and set bail for $180,000. Because I could not make such a high bail, I was returned to the county jail, issued a jail uniform, and placed in a cell.

8. Each week, I was transported from the jail in handcuffs and leg shackles to Medical for my prenatal care appointments. It was very embarrassing to be seen in public this way. I learned later that news of my arrest had been on the front page of our local newspaper. I was totally embarrassed. Once, when I was at the clinic for my appointment, a nurse asked the jail officer if my shackles could be removed, but otherwise I was always in handcuffs and shackles even at the doctor's.

9. Almost three weeks after I was first arrested, I went into labor. I was again transported in handcuffs and leg shackles to Medical. I went through all my labor and delivery handcuffed to the bed. For the two days I was in labor, I couldn't get up and walk around, or change positions, or really do anything to make it easier on me. After two days, the doctors performed a cesarian section. My little girl was born healthy and has remained so. She is now five and a half years old, and is doing well in school.

10. After the delivery, a nurse brought my daughter to me to

let me hold her, but then took her away. Apparently, they weren't supposed to have let me see her, because then they discharged her to DSS custody. I was told that in order to get my daughter back from DSS I would have to go into a substance abuse program for at least six months. I went through the program, and during this time, my daughter was in temporary foster care with her paternal grandparents. She now lives with me.

11. I stayed in the hospital for about a week. A uniformed security guard was outside my door the whole time. I was discharged from the hospital and released from police custody at the same time. I never paid any bond, and I did not return to jail. As far as I know, they just let me go. I had to go to roll calls a few times, but then I never received anything else about my arrest. I do not know if the charges were dropped, or what happened to my case. No one ever offered me treatment in relation to my arrest.

12. This whole experience was embarrassing and hurtful. I was forced to be in jail for the last three weeks of my pregnancy. I was embarrassed by the arrest and the publicity around it, which let my family and friends know about my drug problem. My daughter has been teased by other children. Even though I would like to put this whole experience behind me, I think it's important for me to take part in this lawsuit to make sure this doesn't happen to any other women.

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF SOUTH CAROLINA
CHARLESTON DIVISION

Crystal M. Ferguson, Theresa Joseph Darlene M. Nicholson, Paula S. Hale, Ellen L. Knight, and Patricia R. Williams on behalf of themselves and a class of women similarly situated Plaintiffs, v. The City of Charleston, South Carolina, Dr. Harrison L. Peoples, Dr. Thomas C. Rowland, Jr., Dr. Stanley C. Baker, Jr., Dr. Charles B. Hanna, Dr. Cotesworth P. Fishburne, Dr. E. Conyers O'Bryan, Melvyn Berlinsky, Patricia T. Smith, M. J. Cooper, Herbert C. Granger, Robert C. Lake, Jr., Phillip D. Sasser, Claudia W. Peoples, Dr. Carroll V. Bing, Jr., Reuben Greenberg, Charles Molony Condon, David Schwacke, Shirley Brown, R.N., Edgar O. Horger, III, M.D., Victor Del Bene, John Sanders, William B. Pittard, M.D., Roger Newman, M.D., Harold Bivins, M.D., Melesia Henry, R.N., Defendants.	C/A No. 2:93-2624-2

DECLARATION of LaVerne Singleton

LAVERNE SINGLETON, being duly sworn, deposes and says:

1. I am an African-American woman currently residing in Hollywood, South Carolina.

2. In early 1989, when I was about three months pregnant with my son, Arneal, I began going to the prenatal care clinic at Medical University Hospital. During my regular visits, I was never told of any significant problems with my pregnancy, other than that my sugar levels might have been a little high. At the clinic, the nurses gave us information and showed us videos about nutrition and other things relating to our pregnancy. However, I never met or

spoke with Shirley Brown, and I do not remember ever talking to anyone at Medical University about drug use during pregnancy. I never signed any special consent forms, and it wasn't until after Arneal's birth that I ever saw the commercials on TV about being arrested for using drugs during pregnancy.

3. When I was about 36 to 39 weeks pregnant, I went into labor, and my water broke. I was admitted to Medical University Hospital on November 9, 1989. Later that day, I gave birth to Arneal through a normal vaginal delivery with no complications. He was and remains a completely healthy baby and child. The nurses then took my baby to the nursery.

4. The first sign I had that there might be something wrong was when, the next morning, I asked to see my baby, and they refused.

5. On the morning of November 10, 1989, Nurse Shirley Brown came into my room for the first time. I had never met her before. She told me that I had tested positive for cocaine and that somebody was going to come arrest me and read me my rights. I had occasionally used cocaine before, but never as a regular thing, and never during my pregnancy. I definitely did not have any kind of problem with cocaine use. I was shocked and had no idea why I was being arrested. I never signed any consent to let my medical records be released to the police. When I asked if I could change into my street clothes first, Nurse Brown refused. She was very mean, and I remember her saying something about how she wasn't going to lose her license over people like me, and that she got

$500 from the state every time she turned "one of you girls" in.

6. A deputy from the Sheriff's office came into my room, told me I was under arrest and read me my rights. The deputy told me she was going to take me to jail. I asked again if I could change out of my hospital gown, but I was not allowed to. I was still bleeding and cramping from having just given birth.

7. The officer put me in a wheel chair, handcuffed me, and put shackles on my legs. She threw a blanket over the shackles so nobody could see them. I was wheeled through the hallways by Nurse Brown, with the officer and a uniformed security guard on either side of me. Everyone was staring at me, and I was completely embarrassed.

8. Outside, it was really cold, and I was in just this hospital gown and paper hospital shoes. I was driven like that to the Charleston jail, and then taken to the County jail on Leeds Avenue. I was still bleeding and cramping, because my cervix had still not completely gone back to its regular size. My underwear was soaked with blood at this point, but they still wouldn't give me any clothes. In fact, I didn't get any clothes until my sister came to the jail five or six hours later.

9. I stayed at the county jail for three days. The jail was disgusting and dirty and I was worried about getting some kind of infection given my condition. For example, the toilet seat had blood on it from somebody else, and I was afraid to sit on it for fear of getting sick. I was finally released on a personal recognizance bond on November 12. I never understood what happened

with the charges against me. For a time, I was told I had to go to a substance abuse treatment program because of the charges against me.

10. Once I was out of jail, I called the hospital to find out about my baby. First, they told me that they didn't know where he was. Finally, they told me that DSS had custody of him. It took me another month before I finally was allowed to take Arneal home on December 10, 1989. Even though Arneal was completely healthy, I was told that DSS would be monitoring him. Arneal has always been a very healthy child. He is now five and a half years old and is doing well in kindergarten.

11. The following year, I was pregnant again. Once again, from about three months into my pregnancy until I gave birth, I went to the prenatal clinic at Medical University, because I thought it was the only place that would take medicaid. On November 10, 1990, I gave birth to my son Arnold in the ambulance on the way to the hospital. It was a regular vaginal birth with no complications.

12. Not long after we got to the hospital, Nurse Shirley Brown came into my room again. She told me she'd "got" me again, that she didn't even have to test me again, because she knew I'd tested positive for drugs the year before. To my knowledge, there was no positive drug test this time; in fact I would be very surprised if they said they had one. I was not using any drugs at this time, except occasional marijuana to calm my nerves. She said that I couldn't be discharged except to the Institute of

Psychiatry, that I had the "choice" of either being arrested or going to the IOP. I was escorted over to the IOP by Nurse Brown and two other people in a van. I thought that I would be arrested if I left, and spent 28 days at IOP. My child was released to my sister. Arnold is now four years old, and has always been a healthy child.

13. I was extremely embarrassed about the arrest in 1989 and then the stay at the psychiatric ward. In 1989, I had lost my home to Hurricane Hugo and was already under a lot of stress. I do not have a drug problem, and I was upset that I was being treated this way. My name was in the papers as having been arrested for drugs, and all my friends and family found out. Even a reporter from another magazine saw my name in the paper and called me to ask me more questions.

14. In 1994, I read in the papers about this lawsuit and realized for the first time that this had happened to other women. I called the reporter and got the phone number for the lawyers representing them, to see if I could become involved in this case. Even though I have tried to put these terrible events behind me, I think it's important that other women are not treated the way I was at Medical University.

Mr. WYDEN. Mr. Chairman, I have no further questions. I'm particularly pleased that Ms. Thorne could come and I want to thank the minority for discussing this with me personally, because I think she's got an important story to tell, the Oregon story, and we want to see more innovative programs at the State level. Obviously, we're concerned about how these programs would fare. And I yield back.

Mr. BURR. Well, I can say, having heard about the Oregon program, I am delighted to see the face behind what my colleague from Oregon has touted with much glee. The Chair would recognize Mr. Barton.

Mr. BARTON. I thank the chairman. I will tell my good friend from Oregon that I will work with him to make sure that not one draconian is cut and I will also make sure that no siliconians are cut, my good friend from California. We're going to reform this program, but we'll protect the draconians and the siliconians.

Dr. McKinney, in your testimony, you say that you don't believe that Medicaid should be based on cash welfare payments that the States have already in place. If we want to reform the formula for Medicaid, what should it be based on?

Mr. MCKINNEY. If I were going to do a new Medicaid formula, I would try to base—it sounds like a simple approach. It seems to me that the money ought to go where the need is, unrelated to other things, and a poverty population that needs certain categories of people who, in fact, need more health care, pregnant women, kids, the elderly, disabled, something along that line.

But a formula that is population-based rather than historically based. The problem is if it's just a historical basis, if that's what we use for our baseline, even if it's a new program, it's inextricably tied to old programs.

Mr. BARTON. So you're basically saying the need-based formula, population, poverty level, things of this sort.

Mr. MCKINNEY. Right.

Mr. BARTON. As an example, again, in your testimony, you indicate that State taxpayers, through local property taxes and county property taxes in counties that then have a county-wide hospital district, put in over $1 billion last year in our State toward the care of indigents.

Under current Medicaid formulas, does any of that count as the State's share of Medicaid expenses?

Mr. MCKINNEY. No—well, I shouldn't say that. There's a piece of that that we use in matching DSH money. There's about probably $250,000 that we use for matching DSH. The billion is a conservative estimate. It's really more than that. I can prove up a billion easy enough.

Mr. BARTON. So the taxpayers in Tarrant County that fund John Peter Smith and in Dallas County that fund Parkland and in Harris County that fund Ben Taub and in Houston County, right next to Leon County, that fund the Houston County Hospital District, in general, none of those funds that the local population taxes so that they can provide health care services are counted.

Mr. MCKINNEY. Right. That's correct.

Mr. BARTON. I don't think you explicitly state this in your testimony, but based on what you do say, I would assume that the

State of Texas does support a block grant approach for Medicaid. Is that correct or incorrect?

Mr. McKINNEY. No, no. That's absolutely correct. Of course, how much we like it is inversely proportional to how many rules we get with it. But the concept is really what we're trying to do in our 1115 waiver. We're trying to use the concept of a block grant to the local area from the State and let the local government or the local entity, it's not even a government, but let the local people have local solutions to local problems.

And, in turn, that's what we would ask from the Federal Government is that we be given an opportunity to have a State solution to a State problem.

Mr. BARTON. And when you talk about the State's pending application for the 1115 waiver, could you give this committee, off the top of your head, and then perhaps come back with more precise information, how long it's taken to prepare the waiver, what it's cost in terms of dollars, what it's cost in terms of staff time, and if, in fact, you didn't have to go through that lengthy waiver application period, how many indigents in Texas could have been provided with health care?

Mr. McKINNEY. Of course, I don't know that I can give you the numbers, off the top of my head. I can tell you that the process through which we have gone, a lot of it has been driven by the need to do just health care reform. As far as the 1115 waiver, the HCFA requirements probably have doubled the staff——

Mr. BARTON. So you would be in favor of reforming, if we keep Medicaid in its current station, in any shape, form or fashion, reforming the waiver process to make it less——

Mr. McKINNEY. Yes, sir.

Mr. BARTON. [continuing] complex, simpler, quicker, more expeditious.

Mr. McKINNEY. Yes, sir.

Mr. BARTON. Finally, Mr. Chairman, I have a question for the gentlelady from Oregon. Then-Senator Al Gore, in 1991, testified before this same subcommittee that your State was making a "tragic choice and a horrible mistake" in going to the system that you all went to in your State. He said that it will result in the death of countless poor babies, and I want to quote him, "A child whose mother depends on Medicaid who must have costly medical treatment or they might be allowed to die, but a child in the very next bed with the very same diagnosis and prognosis whose mother is a State legislator would be treated." That was in 1991 when he was a Senator from Tennessee. Can you tell me today whether the Vice President's prediction was right or wrong with respect to your program in your State?

Ms. THORNE. As I said earlier, we had bipartisan opposition on this program, also. But it was President Clinton's administration who did give us waiver approval. From the beginning of the health plan, which has been about 18 months now, we have not heard—I mean, the types of services that are at the bottom of the list are generally not the types of services that will result in someone living or dying.

They, in many cases, are for conditions that will get better on their own or where the treatment is questionable in terms of its ef-

fectiveness. We had reporters out 2 weeks after the program and started looking for people who had died, and, fortunately, we couldn't give them any examples. And so I think that the legislature has recently redrawn the line. And we have an application in to HCFA with a 25-line reduction, but we are still probably 25 lines from being to any treatment that would be a life or death type of treatment.

Mr. BARTON. I assume what you've said is—if I had to shorten it to yes or no—the Vice President was wrong.

Ms. THORNE. I would say that, yes.

Mr. BARTON. Thank you, ma'am. I yield back.

Mr. BURR. The gentleman's time has expired. The Chair would recognize Mrs. Lincoln.

Mrs. LINCOLN. Thank you, Mr. Chairman. As I think Mr. Corker mentioned in his testimony, you all have really faced a great deal already of the challenges that we at this subcommittee and committee level and certainly in Congress face and I'd like to applaud your bravery in meeting those challenges of trying to make something that has been unworkable more workable for the States.

You've worked hard at getting a bigger bang for your buck and I think that that's really a lot of what we're trying to do here by realistically looking at what the Medicaid program can do and how we can cover more people and services. The capability of what Tennessee has done, with 95 percent of Tennesseans now being offered health care, is an important move in a direction that we all want to go.

So, again, I applaud your bravery and your courage at hitting that challenge head on. But there are some realities and I think it's important for us to recognize those and for us to learn from your experiences, and I know that's why you're here today.

Mr. Corker, from the information that I've gathered from the Urban Institute, they have estimated that the State of Tennessee would lose $5.1 billion in Federal funding over the next 7 years under the proposed Republican budget plan to cut Medicaid by $182 billion. This is a 21 percent cut. In addition, this organization estimates that Tennessee will have to cut eligibility by about 8 percent by the year 2002, and that would, I think, translate into terminating coverage for about 106,000 people in Tennessee.

You, in your testimony, stated that in Tennessee, you believe you can offer insight into ways that costs of providing indigent health care can be contained without sacrificing the quality of that health care. And I guess just in reality of what that bottom line is, under current funding, you've had some success in being able to provide more health care, but you've also run into obstacles.

Outside of the current funding, when you talk about a 21 percent cut, how will you do that? With these massive projected cuts and the growing Medicaid population which we're all seeing, how can you possibly believe that the quality of care per your recipient will not be sacrificed or that you will be able to meet that increasing demand in terms of Medicaid individuals when you're seeing that drastic of a cut?

Mr. CORKER. Of course, we've seen a whole series of formulas. We don't know which one that you're talking about. Most of the ones have focused on——

Mrs. LINCOLN. The one that's in the Republican bill.

Mr. CORKER. Most of the ones have focused on capping growth at 5 percent, which we would be more than glad to live with. Our waiver now does that in the third and fourth and fifth years anyway. So we'd be more than open to looking at something like that.

If, in fact, there were dollar cuts, we pay X capitation rate per individual enrolled and it would be very easy to do the math; that if, in fact, there were cuts in the program, you all fund about two-thirds of the cost right now, you could just take that and divide it by the capitation rates. And if there was a 21 percent cut, then we'd have that many less enrollees in the program.

I think what I'm saying and what I said was that we were able to take the dollars that we had in the State of Tennessee and by applying the market principal, by applying managed care, by employing private HMO's and MCO's, we were able to cover another 50 percent of the Tennesseans, and I think that's something that other States will be embracing, there's no doubt, in my mind.

Some of the biggest obstacles we now face really is ensuring the quality of care through those HMO's and PPO's and dealing with the tremendous change that's taking place in Tennessee right now in the health care system that needs to take place in every State in America. So as far as the 5 percent caps that have been discussed in the House and Senate, we'd be more than willing to live with those.

As far as respective dollar cuts, we've seen those all over the board and I really can't respond directly to that. But, again, you could take the capitation rate, divide it out and it would be that many less Tennesseans covered.

Mrs. LINCOLN. So you are going to eliminate or you're going to minimize what kind of coverage you can offer and possibly——

Mr. CORKER. Well, I'm——

Mrs. LINCOLN. You either need to drop services or drop people.

Mr. CORKER. Well, with less dollars, if there are, in fact, less dollars that end up flowing to Tennessee, we're talking about less net dollars. We're not talking about less based on projected growth. I think maybe that's what you're looking at.

If it's actual net dollars, yes. If it's less dollars based on a national growth rate, I would not say that. I would say that Tennessee, based on the principles we've applied, could live with a real net growth of 5 to 6 percent a year and do very fine with our population.

Mrs. LINCOLN. But what you're basically saying is that under the current funding, you've been able to do what you're able to do. But with less funding and in that decrease in the amount of increase, that you feel like you would not have to drop services.

Mr. CORKER. That's correct.

Mrs. LINCOLN. Or you wouldn't have to drop people.

Mr. CORKER. If it's not a net decrease, if it's just a decrease in the amount of growth nationwide, based on what we've seen, we think we would be Okay, yes.

Mrs. LINCOLN. Just one further question.

Mr. BARTON [presiding]. The gentlelady's time has expired, but we'll give her one more question.

Mrs. LINCOLN. Thank you. I appreciate that, Mr. Chairman. You talked about the satisfaction level in terms of the people of Tennessee and that you were getting rave reviews of the program. There was a survey taken in 1994 that reported that 45 percent of the enrollees were less than satisfied with the service.

Mr. CORKER. That's correct.

Mrs. LINCOLN. And I guess I would just be curious to know—I mean——

Mr. CORKER. The program was——

Mrs. LINCOLN. I know there's problems that——

Mr. CORKER. Sure.

Mrs. LINCOLN. [continuing] you have to work out and you have to iron out. I would like an answer to that, as well as to whether or not you've surveyed the doctors and the medical technicians that have been involved in TennCare.

Mr. CORKER. Yes. What we did, we came into office in January, we immediately began working closely with providers around the State. We created a roundtable. We started working closely with the TMA-THA, and we developed a very solid relationship with those groups now.

Obviously, a survey was done. TennCare was implemented in 42 days, unlike some of the other States. It was implemented in 42 days. Provider input, frankly, was not there to the level it should have been. There was tremendous dissatisfaction in 1994. It's 1995 now. We've been involved in it for 18 months and I would say that that satisfaction has risen greatly.

I'd say the providers are very much more on board. The lawsuits that were generated by the TMA have now been dropped and I think that TennCare is moving along. I think that where we are in TennCare is basically in a very early stage. I think the things that we're going to see in the next 24 to 36 months as far as systems being created, sophistication in the MCO's, is going to greatly increase. And the fact is any time you go down a road like this, there are going to be bumps.

I'm sure when Medicaid was created in the 1960's, there were a lot of problems the first 1 or 2 years. We have to, as a country, embrace the concepts of TennCare. I know we will, as a country, embrace the concepts of TennCare ultimately. I don't know how long that's going to take. And all I'm saying is we've done that. We've seen, I think, great fruits from that. We've been able to cover hard-working Tennesseans who did not have insurance before as a result and we've been able to use resources and let them go a lot further than in the past.

Mrs. LINCOLN. So you all will probably do another survey to see how 1995——

Mr. CORKER. Absolutely. And we continue to be involved in both advocates for the poor, the providers. And I think the open arena that they're now dealing in is far more comfortable to them.

Mrs. LINCOLN. Well, we'd appreciate at this committee any results from your survey in 1995. I'd like to thank you all for the pioneer business you've been in and for helping us learn about it.

Mr. CORKER. Thank you.

Mrs. LINCOLN. Thank you.

Mr. BARTON. Thank you. And as a representative from Texas, we want to thank Tennessee for sending us Davy Crockett and Sam Houston. There wouldn't be a Texas if there hadn't been a Tennessee.

Mr. CORKER. We like to remind you of that. Thank you.

Mr. BARTON. Well, we know it and we're appreciative. Before we recognize another distinguished Texan, Mr. Hall, the chairman would like to put into the record, just to make sure that we calm any jittery nerves out in the audience, that the conference report on the budget shows an increase in the Federal share of Medicaid for next year of 7.2 percent and the year after that 6.8 percent, and each year after that of 4 percent. So that for the 7 years that the resolution covers, each year there is an increase in Federal funding for Medicaid to cover the cost of inflation, plus what's assumed to be population growth.

We may change the way the funds are distributed and change the groundrules in a Medicaid reform package, but we're not contemplating cutting funding to the States. The Chair will submit this table for the record at this point in the record.

[The information follows:]

FUNCTION 550: HEALTH

The House budget resolution provides $955.3 billion in budget authority and $955.4 billion in outlays over seven years. The Senate amendment provides $958.9 billion in budget authority and $957.7 billion in outlays over seven years. The conference agreement provides $949.7 billion in budget authority and $949.2 billion in outlays over seven years.

House resolution

For the Medicaid program, the House resolution provides $768.1 billion in budget authority and outlays over seven years. The House resolution assumes that the Medicaid program will be converted into a block grant to the states. Medicaid outlays would grow by 8 percent in 1996, 5.5 percent in 1997, and 4 percent each year thereafter. No assumption is made about the distribution of funds among the various states.

Function 550 discretionary spending in the House resolution is $146.8 billion in budget authority and $147.7 billion in outlays over seven years. The resolution assumes a five percent reduction in funding for the National Institutes of Health, elimination of the Agency for Health Care Policy Research, and a 50 percent reduction in National Health Service Corps, Maternal and Child Health Care and Preventative Care block grants. Also, it assumes elimination of a number of duplicative and non-essential programs, primarily those that could not be justified as federal functions.

Senate amendment

The Senate amendment assumes that a restructuring of Medicaid will occur, in which significant amounts of flexibility will be given to the States. The Senate amendment is designed to be compatible with a wide range of Medicaid restructuring proposals. The Senate makes no assumption about individual entitlement, eligibility groups, benefits, payment rates, financing structures, or the distribution of Federal funds among the states within the total Federal funding levels specified. The Senate does assume that the present aggregate ratio of Federal to State funding (57 percent Federal, 43 percent State) would continue.

The Medicaid outlay levels in the Senate amendment could be achieved in several ways, including a Medicaid block grant, in which aggregate Federal payments to states grew at the following rates from the 1995 Federal base level:

Benefits and Administration

	Percent
1996	8

Benefits and Administration—Continued

	Percent
1997	7
1998	6
1999	5
2000	4
2001	4
2002	4
After 2002	4

The Senate recognizes that block grants represent a significant change in the fiscal relationship between the States and the Federal government. Such a change can take time to implement. The Senate urges the Finance Committee to consider, where appropriate, other means of achieving the first year savings targets to provide States with the time necessary to adapt to a block grant.

The Senate's discretionary assumptions are quite similar to the House's. The Senate amendment assumes that 19 Public Health Service programs would be consolidated into a single State Health Block Grant. There is significant overlap between the Senate's list for the block grant and programs the House assumes will be reduced or terminated. The Senate assumes a one percent reduction in funding for the National Institutes of Health.

The Senate amendment assumes a change to the Federal Employee Health Benefit (FEHB) program. This assumption is described below in the conference agreement.

Conference agreement

The conference agreement provides $773.1 billion in budget authority and outlays on Medicaid over seven years. This level is compatible with Medicaid growth of 7.2 percent in 1996, 6.8 percent in 1997, and 4 percent each year thereafter, or with higher growth rates of benefits and administration if disproportionate share hospital payments are frozen at 1995 levels. The conference agreement assumes that the present aggregate ratio of Federal to State funding (57 percent Federal, 43 percent State) would continue. The conference agreement does not make explicit assumptions about individual entitlement, or about eligibility groups, benefits, payment rates, financing structures, or the distribution of funds among the states. These decisions will be made by the committees of jurisdiction, and ultimately by the House and Senate.

MEDICAID OUTLAYS IN THE CONFERENCE AGREEMENT

	Dollars in billions
1995	89.216
1996	95.673
1997	102.135
1998	106.221
1999	110.469
2000	114.888
2001	119.483
2002	124.263
7-year total	773.132

The conference agreement accepts the Senate's assumption on the Federal Employee Health Benefit program. This assumption would save $6.3 billion over seven years in discretionary spending for current Federal workers, and $4.9 billion over seven years in mandatory spending for Federal retirees. Federal agencies would follow the lead of the private sector by contributing a fixed dollar amount to Federal employees' health plans, thus encouraging Federal employees to make more cost-effective decisions in the allocation of their compensation. This fixed dollar amount would be indexed to inflation. Federal agencies would no longer provide extra subsidies to those Federal employees who choose more expensive health plans. Federal employees would be able to avoid most of the burden of this policy change by choosing more cost-effective health plans. Those Federal employees who continued to choose more expensive health plans would bear the full economic burden above the amount of the Federal contribution. In an era in which health spending is rapidly

spiraling upward, the Federal government should encourage employees to purchase more cost-effective health plans. These savings are included in function 550.

The conference agreement has lower discretionary spending than both the House and the Senate. This is a result of House acceptance of the Senate FEHB assumption, and Senate acceptance of several other House discretionary changes. The conference agreement compromises on the National Institutes of Health, assuming a one percent reduction in 1996, and a three percent reduction from the 1995 level thereafter. This results in a $2.1 billion reduction in outlays over seven years, compared with $0.8 billion in the Senate and $3.6 billion in the House.

The conference agreement assumes that the Office of the Surgeon General will be terminated.

Mr. BARTON. The Chair would now recognize one of many distinguished Texans in the Congress, the Honorable Ralph Hall of Rockwall.

Mr. HALL. Thank you, Mr. Chairman. Dr. McKinney, I think you or someone inquired a few moments ago about block grants and how you would handle them. And I know your fine Governor's attitude toward that.

I think I would just urge you to do battle with the Texas delegation behind you and other delegations who have an unfair allocation and fight for the fair share allocation. I think that's what you're saying. You said something, if the allocations were fair or proper or something, that you could live with it very well.

And under the leadership of Laurie Rich and others and the two Senators in the Texas delegation, we really need to hang together and work on that because there are some inequities there that you're well aware of.

Mr. MCKINNEY. Absolutely.

Mr. HALL. I didn't get to hear your testimony, but I'd already scanned it. You talk about consolidating Medicaid with our local indigent health care programs, that you're already underway on that and that you have some experience in that. You talk about your local options to design and to run the program.

I'm a great believer in local control, but I really wonder if you have a plan or what type plan you've devised to monitor and to ensure fair competition and fair quality and availability of care and responsible spending in the regional or local systems that may not have quite the push that some others have.

Mr. MCKINNEY. We have a plan. Part of the idea is that it's not just local control. There's also local responsibility. The financial part of it is really easy. We determine how much it should cost, how much we can negotiate a rate, what the coverage rate will be, and if the coverage that is required actually runs more than that, then the problem of paying for that and the responsibility for paying that falls to those local taxpayers.

So it is not just local control. It's local responsibility. They are, in turn, responsible for seeing that the system works.

Now, as far as the quality of the care, we'll have standards. We will have not just process measures. We're going to have some strict outcome measures. We'll also have some process measures, immunization rates, low birth weight rates, and some of those requirements will be written into the contracts, even to the point of administrative penalties for failing to meet those.

We will exercise oversight and review of records, of course, financial audits and things like that. The competition part is an un-

equivocal part of it. It's in the law, first, that there has to be competition.

The structure of this local entity that will make the decisions is weighted so that the taxing entity that's contributing the money also has control of most of the money. But there is a responsibility that they have multiple competing, truly competing, not just a shell game, but truly competing plans. If there is only one managed care organization in an area, there must be a primary care case management, enhanced primary care case management.

So the assurance that I can give you right now that there will be competition is that for the next 2 or 4 years, depending on what the State Senate says, the person that has to sign those contracts is going to make sure that there is competition, truly competition.

I think that there is not a problem. We have enough interest right now in Medicaid. It's the nicest feeling I've had in the 18 years I've been trying to mess with this. I now have people begging me for Medicaid patients instead of the other way around. And competition will be assured and we have an intent and have a plan to assure that that happens.

Mr. HALL. I noted on page 7 of your remarks you talked about restructuring managed care and then you set out the two projects that had covered over 80,000 Medicaid recipients and you talked about the results of those.

I'm glad to see that your pilot program showed a 45 percent increase in physician participation. Given the complaints that I hear from my constituent health providers about Medicaid and Medicare and managed care, I'd thank you if you would explain what you believe led to the increase in provider participation and, I guess, satisfaction, apparently.

Mr. MCKINNEY. Yes, sir.

Mr. HALL. Do you think that with the expanded program, as it gets bigger, that we can expect continued increases and continued satisfaction?

Mr. MCKINNEY. Yes, sir. Well, part of what I think led to it is just hard work. I mean, they don't like Medicaid and they don't like managed care and it was our job to sell them managed Medicaid. So that was pretty tough. We've spent a lot of time in educating providers and the clients both, and that helps. That was one of the biggest complaints from the providers.

The other thing is in our contracts with the HMO's, they're commingling. It's not that you're a Medicaid provider or you are a private care provider. It's a provider for the HMO and our patients are treated more the same as everybody else. More and more they're being treated the same. So in the provider's eyes, they are viewed the same.

Participating in an HMO has encouraged the physicians to take more patients because, again, they get private patients along with them, and, No. 2, they now have built-in referral systems. We've got three new pilots that we're having hearings on right now and we had one yesterday in Tarrant County, one today in Lubbock, and then we're going to do San Antonio on the second.

Three years ago, if we had gone to talk to San Antonio, I probably would have got run out of town on a rail. And now we're invited time and time again to come help them get ready for this. So

I think just the progress of managed care has helped some. The education has helped some.

Mr. BARTON. The time of the gentleman has expired.

Mr. HALL. Mr. Chairman, my time has expired and I will yield back my time, with you giving me the allowance of saying to you seek out the other States who have unfair allocations and really get together with them and let's see that this thing is done fairly. Thank you.

Mr. BARTON. We thank the gentleman. The Chair notes that for the first time since he's been in Congress, the only members in the room are all from Texas. I'm tempted to ask unanimous consent to suspend the rules and offer a motion that lets the Director of Health and Human Services of the State of Texas allocate the formula for Medicaid.

Mr. HALL. Might even get the supercollider back.

Mr. BARTON. We wouldn't have trouble at subcommittee, but we might have trouble at full committee. So the Chair would not offer that motion, but would recognize another distinguished member of the committee and from Texas, the Honorable John Bryant, who now represents Leon County and Centerville, Texas in the House of Representatives. Mr. Bryant.

Mr. BRYANT. Thank you, Mr. Chairman. I'm pleased to welcome my friend and former constituent, and he may be my constituent again someday, too, Dr. Mike McKinney. Dr. McKinney, you've just talked about a lot of innovative things you're doing. They're being done under the current system, however, and you have testified today in support of the dramatic changes in the system that are being proposed by the new majority here.

It seems to me like it's a little bit curious, if this much is being done now, why the enthusiasm for the change.

Mr. MCKINNEY. It is curiouser and curiouser. I think that, first off, the changes that we're contemplating are changes that should fit very nicely under a block grant proposal. We're trying to take funds from three different areas that we're already spending and people that we're already covering in three different areas and, under a matched scenario, we're trying to put all that into a single system.

If it were a block grant where we were just getting Federal dollars, not based on a match, we would probably do the same thing. I mean, I think the local entities would look different, mind you, but I still think we would be trying to emphasize the ability of local entities and local people to make decisions about the local problems.

Mr. BRYANT. But my point is the impressive things you talked about are being done now without going to a block grant capped program. Second, it's a puzzle to me that with our State presently, if one is advocating covering Medicaid eligible people, when the law now provides that they have to be taken care of, if they're eligible, and the Federal Government has to match on a formula basis what the State pays to do it, that now our State leadership would come forward and ask you to come and testify in favor of block grants and caps, which obviously mean that if the money runs out, you can't serve all those people.

Mr. McKINNEY. I'm not sure that I understand what you're saying. The truth is if nothing changes, if no law passes, if no block grants occur, all these cuts and the reductions, we're going to do those anyway. We are absolutely going to do the quality and the access to care and the budget controls regardless of what happens.

Mr. BRYANT. They total $11.1 billion over 7 years in Federal money for Texas. Are you going to cut that much?

Mr. McKINNEY. As funny as it sounds, we've never had any trouble spending all the money that they sent to us. So it's easier to be innovative, to do new things, with unlimited resources. We recognize that. But in reality, we are going to do some of these things anyway. We're going to do some of the innovative things that, in fact, save money. So the formula is real important to us.

I will tell you that the funding formula becomes very, very, very important to us, because our growth rate in case loads alone is somewhere between 3.2 and 4.1 percent. If we go to a 4-percent cap State-by-State, not nationwide, but State-by-State, that's a problem. Our case load growth rate alone is almost the equivalent of the floor.

Mr. BRYANT. Basically, you are joining the chorus of folks that have come and said go ahead, we like the block grants, we can handle this, give us a block grant, we'll do our own system, we'll take care of ourselves, we'll take care of the people and all that.

I want to observe that prior to your arrival in this office and prior to the current administration's arrival in Texas that the Congress mandated this early periodic screening, diagnosis and treatment program which required, among other things, checkups and so forth for the indigent population out there and that the State of Texas did not do what it was supposed to do, got sued. It turned out that less than 30 percent of the eligible kids were even getting one checkup a year and had to enter into a final—that is a settlement of the lawsuit, agreeing to do what the law said they were supposed to do anyway.

It raises a question about what a State will do if it doesn't have any mandate at all, when, when it had a mandate, it didn't do what it should have done for those eligible people. Is that a fair thing to worry about?

Mr. McKINNEY. Yes, sir. I think you need to worry about that. I would point out that in this new program, even without any kind of Federal mandate, without any statement that we've got to do all this, we are innovatively trying to find a way to add somewhere between 500,000 and a million new people to the Medicaid system.

So I think that we recognize that we have an obligation and we are real intent on taking care of the health needs of our citizens. I think we are less intent on seeing to the persistence of cash grants from welfare and insofar as those two have been tied in the past, we'd like to see those ties separate.

Mr. BRYANT. Finally, with regard to the formula——

Mr. BARTON. This will have to be the gentleman's last question. But we've shown great discretion and other members have gone over and we're certainly going to let Mr. Bryant.

Mr. BRYANT. Thank you. I just wanted to ask one more time for Dr. McKinney to articulate our common objection to the pending formula right now so that it's very clear for the record just why we

object to it, as Texans and some of the other States who are in the same shape we are in, and what the formula ought to be.

Mr. McKINNEY. My only concern with the formula, first off, if it goes to a national cap, national being the key, of 4 percent, we will live with that, we can make do with that, if the distribution is fair. The truth is it's my job. So no matter what you do, we're going to make it work. But in the sense of fairness, we are very, very concerned that the dollars go where the people are, some semblance of being based on population and population growth. That's our main concern.

Mr. BRYANT. Should we oppose it if they don't change the formula?

Mr. McKINNEY. Should we oppose it if they don't change the formula in regards to making to on a—if it's a 4-percent State, we can still do it. With all due respect, that's something that you know more about than do I. But if you're asking me can we make the program work on a 4-percent floor, then the answer is yes. If you ask me will it work as well as it does with a 4-percent Federal cap distributed, the answer is no. I can do it better with a more fair formula, but I still, regardless of what you do, if you go to zero, can we make it work, yes. It won't look very nice, but we can make it work.

Mr. BRYANT. Thank you.

Mr. BARTON. Thank you. The Chair would, before recognizing Mr. Waxman, indicate that the Director of the State of Texas Office of State and Federal Relations, Ms. Laurie Rich, is in the audience and we appreciate her being here. I would now recognize the former subcommittee chairman and an expert on the Medicaid program, Mr. Waxman of California.

Mr. WAXMAN. Thank you for your recognition and kind words. Dr. McKinney, just to follow-up on those questions. If you had a 4-percent ceiling on Federal dollars and we didn't change the formula allocation, are you saying you can live with that?

Mr. McKINNEY. If we have a 4-percent ceiling, period.

Mr. WAXMAN. Yes, sir.

Mr. McKINNEY. I mean, are we going to have to do some things different? Yes. We will freeze some prices and we will ratchet down. But currently our case load growth is a little bit less than 4 percent. So, yes, we can do it.

Mr. WAXMAN. I think you make a compelling case, given the demographics of your State, Florida, California, those growth States, that the formula has to be—if there's going to be a splitting of the pie—changed so that those States get more money in the formula. But that may not happen and they may work on the existing formula and freeze it in place, which disadvantages Florida, California and Texas, I think unfairly. But whoever is going to end up with less is going to feel they're unfairly treated.

If that's the formula that's put into place and then there's a 4-percent limit on growth of Federal dollars, you say you'll live with it and it will be messy. Tell me what messy means.

Mr. McKINNEY. There's two questions. Can you do it, and the answer is yes. The next question is is it fair, and the answer is no.

Mr. WAXMAN. In what ways will it be unfair? To whom?

Mr. McKINNEY. I mean, in all fairness——

Mr. WAXMAN. Will it be unfair to women and kids that might not be able to——

Mr. MCKINNEY. It's unfair to women and children, it's unfair to the taxpayers, the taxpayers of Texas. I mean, we basically, unless you're going to put a 4-percent cap on the amount of taxes you take from us, there's a little problem with that, unless you do a State-by-State cap. And all kidding aside, I know that's not going to happen. But I think that——

Mr. WAXMAN. You'll live within whatever the numbers are, but that means that your State is going to have to figure out how to deny people care.

Mr. MCKINNEY. I think there's a——

Mr. WAXMAN. You can't cover everybody.

Mr. MCKINNEY. That's true. We don't know. Regardless of how we do this, there will be unmet need. When we get through in the current system with unlimited funding, there will still be unmet need. I don't think that's going to go away.

Mr. WAXMAN. Now, when we devise a base from which to start to give increases for the future, Texas, California, Florida would argue we need to change the base. I assume that in Oregon and Tennessee, you think the base ought to start with what you're spending now, because you've been so innovative in your plans under the waiver. Wouldn't that be an accurate statement?

Ms. THORNE. For Oregon, I would say we'd argue to start with the base that there is now. But we would like to take into account demographics, such as population growth, percentage in poverty, population 75-plus. If there would also be some way to take into account something I had mentioned earlier, which is for those States that have already done the big kinds of things that get us money, the managed care and the long-term care savings, to somehow acknowledge that we have already started from a pretty skinny base, if there is a way to acknowledge that, also.

Mr. WAXMAN. Well, the problem I think we're going to find is that Tennessee and Oregon have gotten waivers to cover more people than other States cover. You could argue you've done it innovatively, but if we recognize that base to start with the fact that you're pulling in more Federal dollars than Texas is per capita or California per capita, we're going to be telling our people in our State that there are a lot of low income people in Tennessee and in Oregon who will get health care, but in our States they won't be able to get health care.

I think that's part of the problem we're going to have if we're going to try to design a base to start with that's fair. Tennessee, for example, has a pretty high base because you had a pretty successful program of provider payments and transfers, which leverage a lot of Federal dollars. You then had a waiver that allowed you to be more innovative, which brought in more Federal dollars. Oregon is covering not just the traditional Medicaid population, but beyond that, although trying to give a thinner coverage of services. But more people are being covered as a result of it and you're pulling in more Federal dollars.

So if we start with the fact that we take you from where you are, you're in pretty good shape for the start. Texas is not in very good shape to start. I just wanted to draw that problem out.

Then my last inquiry, Ms. Thorne, is that in your testimony, you indicated that because you're so much more innovative in Oregon, where you cover more people, you expressed some concern that you might be a magnet to draw people from other States. Now, if that's the case, aren't we really setting in place a strong incentive for States not to be innovative so that they don't become magnets for other States' poor people to come in and be eligible for Medicaid?

Ms. THORNE. There is that possibility and that's why I think we would argue that there still needs to be a level of holding States accountable. What we don't want is everything that's in law right now and just tell us live with the less money, but that there should be some framework of accountability. We have done some innovative programs in Oregon. There may be some other States that take the money and do other things with it. I think there was some discussion this morning about a race to the bottom.

If that does begin happening, then I think within Oregon, we would have to question can we afford an in-migration from other States.

Mr. WAXMAN. Even though you could be really warmhearted and compassionate and want to do things for poor people. You won't be able to afford it and you'll be giving all the wrong incentives. You'd be making your problem for the State worse rather than better by being such good people. I think that's a wrong incentive for the Federal Government to put in place.

Thank you, Mr. Chairman.

Mr. BILIRAKIS. Thank you. I thank the gentleman. Ms. Thorne, I know this is a subjective thing, but would you say that your program in Oregon is a better program than in the surrounding States?

Ms. THORNE. I would say now it is. We have coverage to the Federal poverty level. We have brought in whole groups of people who would not be able to qualify in surrounding States. The benefit structure is different with our priority list, but we are also covering some services that may not be covered in some surrounding States.

Mr. BILIRAKIS. Do you have a migration?

Ms. THORNE. We have not, so far, seen that, probably because, also, our welfare system is not as good as some of the surrounding States. So that may balance out in terms of payment levels. And that was a real concern of our legislators when we began this program—are we going to see in-migration. There is some level of standardization among Medicaid programs, so there is some basic requirements that are out there now. We have not seen in-migration to this point.

Mr. BILIRAKIS. Thank you. I will excuse this panel. Thank you so very, very much. You've been very helpful.

Panel 3, Ms. Debra Ward, Director of Government Relations, United Health Plan; Ms. Judith Stavisky, Associate Vice President for Health Services, Mercy Health Plan, out of Philadelphia; Mr. Michael W. Murray, Executive Director, Health Plan of San Mateo, California; Ms. Maura Bluestone, President and CEO of the Bronx Health Plan; and, Dr. Jesse Jampol, HIP Health Insurance Plan, out of New York.

Again, your written statements are a part of the record. I would appreciate it if you would try to limit your opening statements to as close to 5 minutes as possible. We'll start out with Ms. Ward.

STATEMENTS OF DEBRA M. WARD, DIRECTOR, GOVERNMENTAL RELATIONS, WATTS HEALTH FOUNDATION, INC., UNITED HEALTH PLAN; JUDITH STAVISKY, ASSOCIATE VICE PRESIDENT, MERCY HEALTH PLAN; MICHAEL W. MURRAY, EXECUTIVE DIRECTOR, HEALTH PLAN OF SAN MATEO; MAURA BLUESTONE, PRESIDENT, BRONX HEALTH PLAN; AND, JESSE JAMPOL, HEALTH INSURANCE PLAN OF GREATER NEW YORK

Ms. WARD. Thank you. Good afternoon. My name is Debra Ward. I'm Director of Governmental Relations with Watts Health Foundation, United Health Plan. It's a pleasure to be before you today to speak on the issue of the transformation of Medicaid. To give you a little background on Watts Health Foundation, United Health Plan, we started in the very late 1960's, right after the Watts riot, as a small community health center and have grown and matured to operate both a federally qualified health center, as well as a managed care program.

We have been providing services on a fee-for-service basis for close to 30 years, 28 years, and was one of the first prepaid health plans in California for now over 22 years. Our prepaid health plan, which is called United Health Plan, has now grown to service about 90,000 individuals. We have a network model. We have now over 180 medical groups in our network, as well as we service not only Los Angeles County, but San Bernadino and Orange County.

Our other programs in terms of our community health programs. We operate two federally qualified health centers and we operate a numerous number of community programs, grants and contracts that are geared toward servicing the homeless, substance abusers, and school-based clinics, et cetera.

I want to concentrate on about five different areas in terms of today's topic, which is the innovations that work within managed care. We have had the unique experience of being able to integrate and wove in a number of programs, both the managed care with our community health programs.

To mention some of those programs which have worked for us and we have seen outstanding results from. One has been the cultural competency of our services, being able to serve individuals with different linguistic needs and cultural needs. We've been able to put together a diverse panel of providers that are represented in different areas within our service area as has been afforded through developing a diverse network, we have been able to identify about 30 different languages that our providers speak and also utilize in our serving our patients.

We put together a number of publications, educational programs, brochures, et cetera. We use primarily four languages. That's English, Spanish, Korean and Chinese. Those are anywhere from our member services, our member information, educational materials, videos, et cetera, are done in all those four languages.

We also have begun to look at the cultural impact of our quality assurance program, our standards and outcomes, looking at how

various communities would design different quality measurements based upon their cultural beliefs and behavior.

Second, moving into access, we have a number of programs that are geared toward access, one of which is transportation. We provide door-to-door transportation to all our patients and to all our medical groups, all 180 medical groups. We have a fleet of about 25 vans and we go on an appointment service with individuals giving us at least 24 hours notice.

We also have, in the south central Los Angeles area, child care that is provided to our patients that need to go and see the doctor, as well as if they need to take their children, other siblings to the doctor. We have a very aggressive follow-up program that is geared toward the heavy number of broken appointments. We do that by having recording messages to remind members of their appointments. We send letters. We do a number of things to try to encourage them to make those appointments.

We also have what we call mobile units, and we call them the mobile health care centers. We have nine of those. They go throughout the county of Los Angeles and they provide services on the steps of churches, parks and parking lots of the parks, Department of Public Social Services, shelters, et cetera.

In those area where we have found there to be a great need in bringing the medical services to the community, we have identified those places and those are the sites that are identified for our mobile care program.

We also, over the last 2 years, implemented an urgent care center in south central Los Angeles. It's 24-hour services. It's geared toward reducing the number of emergency visits. We have found that to be very successful in reducing our ER visits, as well as it helps us with our broken appointments. Individuals, when they come into the centers during the day, those who do not have an appointment, we generally send them to the urgent care center. That way, we keep the integrity of the appointment system ongoing and, yet, we meet the needs of individuals, our community members who need to see a doctor right then and there. We do not turn them away.

Also, I'd like to mention, in terms of access, our medical card. Every individual is given a medical card. On that card, it's really important and we have found it to be helpful to print the individual's medical group or primary care physician's number.

Mr. BILIRAKIS. Please summarize, Ms. Ward, if you will.

Ms. WARD. Certainly will.

Mr. BILIRAKIS. Thank you.

Ms. WARD. And with that number, the doctor has been able to meet that individual at the ER or has been able to provide the information to the individual by phone.

In closing, there are a number of other programs that we provide in terms of incentives and targeted programs that are geared toward our prenatal population.

I would just like to say that we stand ready to work with this committee and staff in designing and drafting appropriate and responsive legislation to the Medicaid population. Thank you.

[The prepared statement of Debra M. Ward follows:]

Prepared Statement of Debra M. Ward, Director of Governmental Relations, Watts Health Foundation, Inc.

I. INTRODUCTION

Good afternoon, Chairman and other distinguished members of the House Committee on Commerce. I am Debra Ward, Director of Governmental Relations for Watts Health Foundation, Inc. (WHF)/United Health Plan, and on behalf of our Board of Directors and President, Dr. Clyde W. Oden, it is a pleasure to testify before you today with regard to your topic the Transformation of the Medicaid Program and the Integration of Managed Care and Community Programs.

Our perspective on Managed Care and Community Programs is enhanced by the fact that we have been serving publicly supported beneficiaries in a managed care environment for twenty-two (22) years. Additionally, our President, Dr. Clyde Oden, was one of the original members of the Advisory Committee to the Commissioner of the Department of Corporations in California in 1975, when the Knox-Keene Health Services Plan Act was passed. WHF has an outstanding background as a safety net provider and is one of the oldest prepaid health plans (PHPs) in the State of California.

II. BACKGROUND ON WATTS HEALTH FOUNDATION, INC.

History has shown us that out of despair, destruction, and tragedy are born new beginnings, hope, and progress. From the smoldering ashes of the 1965 Watts riot rose the Watts Health Foundation, Inc.—the new beginning that brought hope and progress to a devastated community. Following the riot in August 1965, the McCone Commission, a group appointed by then-Governor Edmund G. Brown, investigated riot-torn areas in California during the 1960s. As a result of the McCone Commission's report, the South Central Multipurpose Health Services Center began in October 1967, as a federally funded demonstration project.

In 1970, the Center came under the administrative control of a Community Advisory Council, who became its Board of Directors. In 1974, the Board renamed the organization the Watts Health Foundation. During the same year the organization started its first prepaid heath care program for Medicaid beneficiaries, named United Health Plan. In 1983, United Health Plan became a federally qualified HMO, and in 1984, started one of the first HCFA risk contracts for Medicare.

Today, WHF has a proven track record in effectively serving the poor, the uninsured, the underserved, and special populations. WHF prides itself on its innovation and creativity. We "go that extra mile" in providing services to a population that traditionally has been overlooked by mainstream health care systems. WHF is composed of two operational systems that have garnered wide praise and have been models for organizations nationwide: Community Health Programs, which focus on operating WHF's federally qualified health centers and public grants/contracts; and United Health Plan, the organization's managed care program.

Through its community Health Programs, WHF has evolved to become one of the largest private providers of primary health care in Los Angeles County, annually serving over 125,000 clients with more than 250,000 encounters a year. WHF serves primarily individuals who have been increasingly disenfranchised by the mainstream health systems—"vulnerable populations," for instance, the poor, elderly, immigrants, addicted, homeless, chronically and terminally ill persons, and those without health insurance. With the support of a network of government and private grants, WHF serves these patients through an unique array of programs (over 30 programs) that have been woven together into a comprehensive service network. The population served by Community Health Programs is approximately 45% African American and 45% Latino the remaining 10% are Caucasian and Asian Pacific Islanders.

The organization's HMO, United Health Plan, whose initial emphasis was on the Medicaid population has evolved to include Medicare, employers, and a voluntary health alliance (Health Insurance Plan of California—HIPC). United Health Plan is the tenth largest HMO in California, and it is the second largest HMO serving Medicaid beneficiaries. United Health Plan has over 90,000 members in Los Angeles, Orange, and San Bernardino Counties. Its dominant markets remain those most vulnerable to issues of access and quality care—Medicaid recipients, who represent 69% of the membership. The Medicare market represents 16%, and the employer-based sector represents 14.5% of the membership. United Health Plan is considered a network model and coordinates services by contracting with group practices, community heath centers, IPAs, hospitals and a broad array of providers.

The mission of the WHF and its family of organizations and programs, is dedicated to building and maintaining individual, group, and community health and

well-being, within a patient driven/quality focused environment. The successful integration of public health programs, community health center services with the benefits of a managed care operation (i.e., UHP) has allowed WHF the ability to provide a multitude of services and to extend itself to hard-to-reach populations. Such experience has compelled WHF to share its experiences and knowledge, and become actively involved in the formulation of national and state focused Medicaid managed care initiatives.

III. THE URBAN CHALLENGE

There is a serious health care crisis in America, due in part to disproportionate numbers of uninsured and underinsured residents; the growing cost of health care and medical technology; lack of access to primary health care providers and accountable medical delivery systems. Other contributing factors include the perpetuation of high-risk lifestyles and inappropriate health seeking behavior. Health status in any community is impacted as much by lifestyle as it is by the availability of health services. Whether the issue is poor nutrition, lack of exercise, excessive alcohol consumption, use of tobacco products, violence, use of illicit drugs, promiscuous sexual behavior, or other adverse social behaviors, lifestyle choices impact health status. All of the above contribute to the tragic statistics of high morbidity and mortality, and represent the greatest challenge to organizations like ours, that seek improved outcomes in underserved communities.

WHF has integrated the principles of managed care and community programs into successful strategies designed to serve underserved communities. WHF's experience has demonstrated that managed health care is an appropriate system of care for the poor and other underserved communities. Having a system whose economic fate is tied to promoting appropriate lifestyle behavior, and seeking early intervention in disease cycles, it is not only cost-effective, but can and must be quality driven.

Some of the special needs and characteristics of serving Medicaid beneficiaries in a managed care setting are listed below:

1. Day-to-day survival proceeds individual health care. 2. Environmental/behavior stressors (violence, anger, etc.). 3. More transient/mobile populations. 4. Reliance on the emergency room for primary care. 5. Doctor "shopping" in order to hear or get what one wants, rather than what one needs in terms of health services. 6. Prescription drug shopping. 7. High frequency of broken appointments. 8. Late presentation for prenatal services. 9. Little regard for preventive health services. 10. Higher levels of use of illegal drugs and legal but harmful substances like alcohol and tobacco products.

IV. MANAGED CARE AND COMMUNITY PROGRAMS

A managed care system that will best serve a population like those listed above must have enough members so that it can address systemic and social issues facing Medicaid beneficiaries. Our experience suggests that there is a threshold level of 20,000 to 30,000 members needed to assure that any managed care system has enough Medicaid members so that special needs are addressed. This population brings special needs that a managed care system must make allowances for, if it is to optimize the opportunity to serve this population. We believe that recognizing special needs and socio-demographic issues is crucial if HMOs are to be agents for change in the community. Such considerations should include, but are not limited to the following:

- **Culturally Competent Services:** Medicaid patients are usually less educated; often much younger heads of household; English, especially American Standard English, may not be the language spoken nor read in the home; and a culture of poverty has become part of their reality. There is generally no sense of planning for the future. Long range thinking for those on the edge in our welfare systems, is a luxury few can indulge. Any health system that has not adjusted for cultural, lingual, and behavior differences, cannot fully optimize the opportunity to serve Medicaid beneficiaries.
- **Access:** This must mean more than the opportunity for essential services to be provided in a timely manner. Our experience suggests that there must be proactive measures to encourage correct health seeking behavior. This means, having programs that lower barriers for low-income patients. Barriers such as transportation, child care for a parent while that parent is seeking care for her/himself or their other children; aggressive follow-up of broken appointments; follow-up of emergency room visits, including visits that are denied because they are not appropriate health seeking behavior. There is also a need for authentic

medical social work to assist Medicaid beneficiaries and the medically indigent in addressing the multiplicity of problems they face.

WHF's approach to the problem of access includes locating facilities in proximity to the neighborhoods in greatest need; hiring full-time physicians and other health professionals to provide services in an efficient context, i.e., group practice; using a fleet of vans to transport patients for appointments; and reducing financial barriers through the use of sliding scale fees for low-income patients.

Our organization pioneered the innovative concept of using mobile medical centers for health care delivery services. Factors such as poor public transportation, gang territories, and transient residents who lack knowledge of existing community resources, create a situation in which it is more feasible for the doctor to go to the patient, rather than waiting for the traditional practice of the patient to go to the doctor. By setting up our mobile medical centers in school yards, in the parking lots of social agencies, churches, and local parks, we have been able to reach persons who have been nearly invisible to conventional health systems.

The National Health Service Corps has been extremely helpful in our recruiting of physicians and other health professionals. The Corps has been our primary means of increasing the number of capable and committed health providers who serve in many urban areas.

- **Incentives:** There are portions of the general population that will not do what is good for them: even if it kills them. Often a managed care system will have to devise valuable, yet cleverly crafted incentives to encourage Medicaid patients to do what is "good" for them. Items such as tee-shirts for fully immunized children; special sweat shirts for pregnant women who keep a majority of their prenatal visits, "cute" condom carrying cases to encourage "protected" sex, etc.
- **Targeted Programs:** WHF has a long-time history in working with local, state and federal health programs. For example, United Health Plan uses the Women Infant and Children (WIC) nutritional program which is open to all low income women in California, to supply supplemental food certificates. With a low percentage of low-income African American women accepting breast feeding, we incorporated the WIC program to help increase the awareness and encourage the practice. We use the program to raise an issue and encourage women to see films and attend educational sessions on nutritional issues. As a result, the use of the WIC program increased the rate of breast feeding from 7% to 30% over 2 years.

  Another program worth mentioning is our "Healthy Black Babies" program developed in 1990, based on concerns that infant mortality among African American females was twice as high as that of white mothers, and more than twice as high as Latino mothers. The program focuses on low-income women by offering free pregnancy tests to the general community; the test is then used as a springboard to introduce prenatal care. A team approach includes counselors, social workers and nutritionists. Attention is drawn to the program by advertising through public advertisements such as billboards and radio. As a result, the Healthy Black Babies program allowed the organization to decrease their infant mortality rate from 20 deaths per thousand to 16.

  Lastly, I would like to mention briefly our "Center of Excellence Program," which was developed to manage the health and social needs of our elderly, patients who are HIV positive, those living with AIDS, victims of cancer, repeat abortions, high risk pregnancies, pediatric patients with high risk diagnosis e.g., asthma, renal disorders, etc.

V. CONCLUSIONS

In closing, I would like to thank the Committee on Commerce for inviting me here to speak. And, we look forward to working with you as action on Medicaid reform legislation proceeds.

Thank you.

Mr. BILIRAKIS. Thank you. Ms. Stavisky.

STATEMENT OF JUDITH STAVISKY

Ms. STAVISKY. Good afternoon, Mr. Chairman and members of the committee and staff. My name is Judith Stavisky. I'm the Asso-

ciate Vice President of Health Services for Mercy Health Plan, which is headquartered in Pennsylvania.

Mercy Health Plan is one of the largest Medicaid managed care plans in the Nation, offered as an alternative to traditional fee-for-service Medicaid in Pennsylvania. Sponsored by the Sisters of Mercy, the plan was developed as part of the Catholic sisters' mission to serve the poor. Mercy Health Plan is a non-profit organization, serving only Medicaid recipients. In our 12 years of operation, we have grown from 300 members in 1983 to over 140,000 members today, all of whom joined the plan voluntarily.

About 5 years ago, Mercy Health Plan was faced with a growing number of infants who were born too sick or fragile to return home. At that time, about a fourth of our newborns remained in the hospital after delivery, with an average length of stay of 15 days. Many of these babies suffer lifelong impairments, neurological or developmental delays, frequent rehospitalizations at an enormous emotional cost to the families and a staggering financial cost to the Medicaid program.

As we looked closer into the issue of detained babies, we found what many of you already know—that the social service needs of low income individuals often drive and are inextricably linked with their medical care needs. Many Mercy Health Plan members simply do not have $3.20 required to take public transportation to their prenatal appointments. Others face educational, language and cultural barriers that prevent them from seeking care.

While these obstacles may not have a medical origin, they certainly bear medical consequences. To overcome these obstacles, Mercy Health Plan has designed an intensive outreach and intervention program around newborns and their moms, called WeeCare. We provide support to individuals throughout their pregnancy and up to 2 months after delivery. Mercy Health Plan has committed 20 nurses, social workers and support staff who strive to identify every pregnant woman on the plan as early as possible.

Many of our members do not have a telephone or a permanent address. So we often canvass neighborhoods to find our members who could not be reached otherwise. The backbone of the WeeCare program is the home visit. During the home visit, the WeeCare staff tries to determine whether the most pressing medical or social needs—some of our members live in buildings that are unsafe for a newborn to return home to. Others have significant mental health or substance abuse problems which keep them from getting to prenatal care. Some require immediate home health services because they might have a high risk medical condition.

The WeeCare staff is there to help find the pregnant woman suitable housing, get them into a drug and alcohol program, or just simply explain their doctor's orders. Mercy Health Plan provides transportation to and from prenatal and parenting classes. We will arrange transportation and pay for transportation to prenatal visits and postpartum visits. We will identify and pay for child care. We will coordinate translation services in dozens of languages and track down emergency food, clothing and temporary housing for our members.

Over the past 5 years, the WeeCare program has successfully reduced the number of detained babies from almost 24 percent of

births in 1990 to 17 percent of all births in 1994. That average length of stay that I mentioned earlier at 15 days in 1990 has dropped to 11.3 days in 1994. For every dollar Mercy Health Plan has invested in the WeeCare program, we have saved nearly $3 in associated costs with detained newborns.

And WeeCare is not the only preventive medicine initiative that Mercy Health Plan has launched. We have also undertaken a city-wide immunization campaign, donating $1.3 million to the Philadelphia Department of Health to establish a computerized tracking system that will benefit all children in Philadelphia. The immunization program is just one example of Mercy Health Plan's commitment to public-private partnerships.

In addition, Mercy Health Plan has financed the cost of developing a school-based asthma program, which has cut participant emergency room use from an average of four visits to 2.8 visits after completion of the program. And last month, Mercy Health Plan proudly launched a pioneer violence prevention program which will grant $2 million over 5 years to 4 to 5 community-based efforts in southwest Philadelphia.

I'm just finishing up. The challenge for a Medicaid managed care organization is to recognize the special needs of low income members and seek approaches that will eliminate their obstacles to care. Mercy Health Plan has shown that it can do just that.

Thank you.

[The prepared statement of Judith Stavisky follows:]

PREPARED STATEMENT OF JUDITH STAVISKY, MPH, M.ED., ASSOCIATE VICE PRESIDENT, MERCY HEALTH PLAN

INTRODUCTION

Mercy Health Plan (MHP) is a managed care organization headquartered in Pennsylvania, offered as an alternative to traditional fee-for-service Medicaid in Pennsylvania. Sponsored by the Sisters of Mercy, Mercy Health Plan was developed as part of the Sisters' mission to serve the poor. Mercy Health Plan is a full-risk health maintenance organization (HMO) model managed care plan. Our members choose to join the plan voluntarily. Our membership growth, from 35,000 in the beginning of 1991 to over 150,000 today, speaks to the quality and range of services we provide to our members. Our commitment to providing quality care has earned Mercy Health Plan the distinction of becoming the first Medicaid managed care plan in the nation to receive full accreditation from the National Committee for Quality Assurance (NCQA).

Mercy Health Plan's membership is young (58.3% under the age of 20), mostly female (68%). About one-fourth of our membership is without permanent housing, residing in homeless shelters or temporary residences. In addition, one-third of MHP members do not have a consistently operating telephone, making conventional methods of communication between a managed care company and its membership an ongoing challenge.

Our practical experience in providing an array of managed care services for the poor has deepened our understanding that the social service needs of our members are inextricably linked with, and often drive, the members' health care needs. The economic status of our membership puts our member, "at risk" for poor health outcomes; these include low birth weight babies, inadequately immunized children, and high rates of youth violence and teen pregnancy.

Mercy Health Plan has committed significant financial and human resources to address the social obstacles that impede our members' ability to obtain regular access to health care. Transportation assistance, to and from medical appointments and reimbursement for both transportation and child care is routinely provided to enable members to comply with doctors' appointments and to attend MHP's health education programs.

Equally important, MHP has developed several preventive medicine initiatives that support our member' efforts to overcome barriers to care. Examples of existing

programs include a perinatal risk reduction program, WeeCare, a city-wide immunization campaign, a lead paint and tuberculosis screening program, breast cancer education, and prenatal, parenting and asthma classes. The following testimony will explain Mercy Health Plan's WeeCare program in detail.

WeeCare Overview

In 1990, Mercy Health Plan established a perinatal risk reduction program to reduce infant morbidity. Mercy Health Plan's WeeCare program was created to respond to a membership whose life circumstances often limit their chances of having a healthy baby. WeeCare is an intensive case identification and case management program, which follows MHP's pregnant members throughout their pregnancy and up to two months after delivery. The goal of the WeeCare program is to detect and resolve medical and social problems early enough in a pregnancy so that those problems can be minimized or eliminated before the baby is born.

The initial home visit and assessment is the foundation on which the case management activities are built, Home visits are conducted by members of the WeeCare staff, which includes Registered Nurses, Social Workers or a Lay Home Visitor. Perinatal case management activities are varied and wide ranging. Finding permanent shelter for homeless members; identifying obstetricians who speak Spanish, Russian or Vietnamese; providing transportation tokens to and from prenatal appointments; locating emergency food, clothing or utility services; and arranging for and following up with home uterine monitoring are all a part of the services offered by WeeCare.

As the WeeCare program grew and its staff expanded, Mercy Health Plan experienced a 28.5 percent (28.5%) overall reduction in the percentage of detained babies (those newborns kept in the hospital after the mother's discharge) born from 1990 to 1994. Equally important, those babies who were born ill or low birth weight, showed a significant reduction in their length of hospital stay (LOS), from an average length of stay (ALOS) of 15.0 days in 1990 to an average length of stay of 11.3 days in 1994. Improving the pregnancy outcomes of MHP members has reduced the risk of life long handicaps for hundreds of infants and has saved millions of dollars in related medical expenses for the taxpayers of Pennsylvania.

While low-income women are faced with numerous obstacles that may prevent easy access to prenatal care, a health maintenance organization can take the lead in eliminating some of those barriers and significantly increase the number of babies born healthy. The information that follows will explain how the WeeCare program is organized and highlight some of the program's successes.

Early Identification of Pregnant Women

Finding MHP members early in their pregnancy is an essential component of WeeCare. Case finding involves Mercy Health Plan's network providers, Mercy Health Plan's internal staff, and local community agencies. The WeeCare program relies on its family practitioners and obstetrical providers to notify the Plan immediately if a Mercy Health Plan member is pregnant. Some of the large hospital clinics fax the names of Mercy Health Plan members who are receiving care at their site. Other providers call weekly with the names of pregnant members. With these systems in place, the WeeCare Case Managers/Care Coordinators can contact members within days of their first prenatal appointment.

To fortify the efforts of MHP's providers, Mercy Health Plan's Claims Department refers every claim for a pregnancy test, a diagnosis of pregnancy or pregnancy related service to the WeeCare staff on 4 daily basis. The WeeCare Case Managers/Care Coordinators follow up with these claims by contacting the member (or provider) to verify the pregnancy or inform interested members about WeeCare services. WeeCare staff also review pharmacy claims for prenatal vitamins, in the event that a pregnant woman filled the prescription, but was unknown to the WeeCare program.

Pregnant women are also identified daily by Mercy Health Plan's Utilization Review Department. Any hospital admission or emergency room use by a pregnant woman is immediately forwarded to WeeCare. While some women are not receiving prenatal care, they may be admitted to the hospital or emergency room for an illness related (or unrelated) to their pregnancy. These admissions are also forwarded to the WeeCare Program for follow up. It has been the experience of WeeCare, that these particular referrals are often women who have not been receiving regular prenatal care.

Mercy Health Plan's Member Services Department lends its assistance to support the plan wide effort to identify pregnant women. If a Member Services Representative learns that a member is pregnant during a conversation on another matter, the

Member Services Representative will promptly connect the pregnant member with a WeeCare staff person.

Some MHP members refer themselves to the WeeCare Program. Others have responded to the member newsletter, which regularly features information about WeeCare activities. The WeeCare staff has also identified a variety of community agencies and grass-roots organizations that serve low income communities. These groups have been essential links to Mercy Health Plan members, and once informed about the program's services, these organizations will refer pregnant women directly to WeeCare. In addition, Mercy Health Plan contracts with the Maternity Care Coalition to assist in our case-finding efforts.

WeeCare Staffing

The WeeCare staff is made up of teams of Registered Nurses (RN), Social Workers, a Lay Home Visitor and WeeCare Representatives who are assigned designated neighborhoods throughout our service areas. Medically high risk members are paired with a WeeCare RN. Those members with immediate social service needs are teamed with a member of the social work staff. The professional and support staff work in tandem to assure that a member with multiple problems is connected to all the resources and expertise required. There are 20 employees on the WeeCare staff.

Mercy Health Plan members who live more than 40 miles from MHP headquarters are visited by one of the Visiting Nurse Associations (VNA) that contract with WeeCare to perform the initial home visit and complete the assessment interview. A WeeCare staff member will then case manage that member by telephone (or provide additional visits, if required) throughout her pregnancy and up to two months after delivery.

Case Management Activities

Mercy Health Plan's Care Coordinators and Case Managers act as trouble-shooters for Mercy Health Plan's pregnant members assuring early access to an obstetrician, facilitating the process of obtaining ongoing care, and actively connecting women to the essential services they require.

Every Mercy Health Plan member who is pregnant and can be contacted by phone, letter, or in person is informed about the WeeCare Program. The WeeCare staff goes to great lengths to track down patients without working telephones or known addresses. If the member does not have a working home telephone but an address is known, the Care Coordinator/Case Manager will send or drop off a "Welcome to WeeCare" letter with a bib at the member's home. If the address is also unknown, numerous telephone calls are placed to health providers in that member's neighborhood as well as pharmacists, public assistance offices, community centers, schools and homeless shelters in an effort to find the member.

The Case Manager/Care Coordinators work closely with a member throughout her pregnancy, and continue contact with the member until the child is two months old. At two months of age, the child (and mother) will be followed by MHP's Immunization Outreach Program.

The duties of a Case Manager/Care Coordinator include: Visiting the member at her residence or establishing a meeting at an alternative location. Assessing the condition of the member's home, environment, and overall well-being. Evaluating nutritional status, evidence of drug or alcohol use, psychosocial needs, making referrals with appropriate follow-up to make sure connections are made with community agencies or providers. Regularly contacting member by phone or visiting the member to monitor pregnancy. Providing education and counseling related to pregnancy and other issues as they become apparent. Determining if other children are receiving regular medical care, or are up-to-date with their immunizations and assisting with selection of a pediatrician, if appropriate. Reiterating the importance of early and continuous prenatal care followed by postpartum and pediatric visits.

Once the initial contact has been made and an overall assessment is completed, the Case Manager/Care Coordinator will connect the WeeCare member to the services she or her family may require. These services could include: Supplemental food available through Women, Infant, and Children (WIC). Utilities assistance. Emergency food or clothing. Temporary or long-term housing. Shelter away from abusive spouse or boyfriend. Transportation assistance, bus tokens, or cab vouchers. Referral to Mercy Health Plan's mental health/drug and alcohol provider for treatment, and monitoring treatment compliance. Identification of and payment to a child care provider to enable member to keep medical appointments. Referral and reimbursement for child birth education classes. Arranging for translation services, if needed. Attending an Obstetrical appointment with the member.

The Case Managers/Care Coordinators maintain contact on a weekly, bi-weekly, or monthly basis, depending on the member's needs and health status. The Case Managers/Care Coordinators also share the WeeCare Home Visit Assessment forms with the member's obstetrical provider to enhance the provider's efforts to deliver the most appropriate care. There is continual communication with the obstetrical provider throughout the member's pregnancy.

Home Based Services

Home based obstetrical care is available for members whose medical, obstetrical, or psychosocial risks prevent the member from receiving prenatal care in a traditional setting or when home care could be an alternative to hospitalization. Home uterine monitors are also available when requested by the provider.

Home Health Aid Services are coordinated by the WeeCare staff when a member is confined to bed rest. Many MHP members may require assistance in walking, bathing, dressing, or child care and do not have family or friends from whom to seek assistance.

If a member is confined to home and requires assistance with light housekeeping, grocery shopping, laundry, meal preparation, and/or household chores, Mercy Health Plan will also link that member with the necessary services and pay for those services.

Prenatal Education

While the WeeCare staff provides ongoing and individualized education for WeeCare participants, Mercy Health Plan offers its own citywide childbirth education classes for members, free of charge. Mercy Health Plan members receive a stroller if they attend 100 percent of Mercy Health Plan's childbirth class sessions. Mercy Health Plan's prenatal education classes have a 92 percent completion rate by the hundreds of women who have taken the class series. The WeeCare program will also pay for WeeCare members to take childbirth education or prenatal exercise classes offered at hospital or community locations.

Postpartum Follow-up

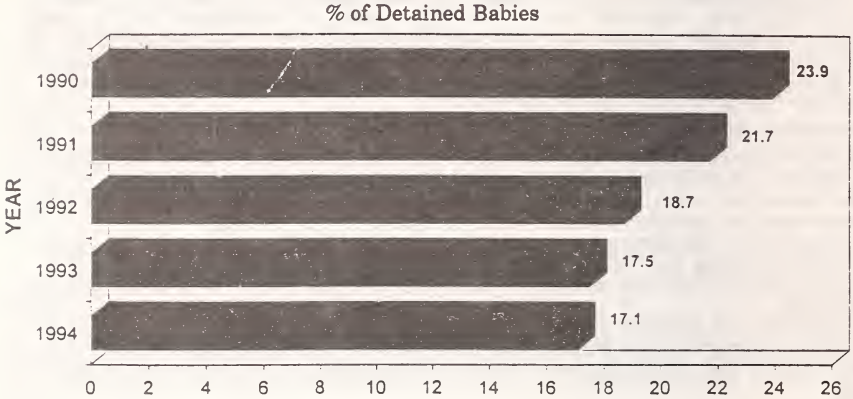
A postpartum visit by a Case Manager/Care Coordinator is attempted in the hospital or scheduled shortly after the baby returns home. This is particularly important for members who do not have a working phone at home. A gift package for the baby is presented to those women who have participated in WeeCare. Telephone calls and/or visits continue for two months after delivery. Postpartum and immunization appointments are made with the member (and newborn) and followed up for compliance.

Decrease in Infant Morbidity

Members of a Medicaid managed care organization in Pennsylvania are permitted to enroll or disenroll from their managed care program at any time during the month. There are no "lock-in" periods where one is required to remain on the Plan for a specified amount of time. Consequently, it is difficult to establish a true infant mortality rate, because some babies may die within a year after birth but would be unknown to Mercy Health Plan because they are no longer enrolled in the Plan. Instead, WeeCare has carefully reviewed the detained babies born on MHP from 1990-1994.

The following chart will compare the "detained baby rate" experienced by Mercy Health Plan in 1990, 1991, 1992, 1993 and 1994. A detained baby is an infant who remains in the hospital after the discharge of its mother. Detained babies are typically born premature, low birth weight or with a congenital anomaly. As the chart below indicates, the plan-wide 23.9% detained baby rate experienced in 1990 was reduced to 17.1% in 1994. Those mothers intensively case managed by WeeCare staff experienced a 15.8% detained baby rate in 1994.

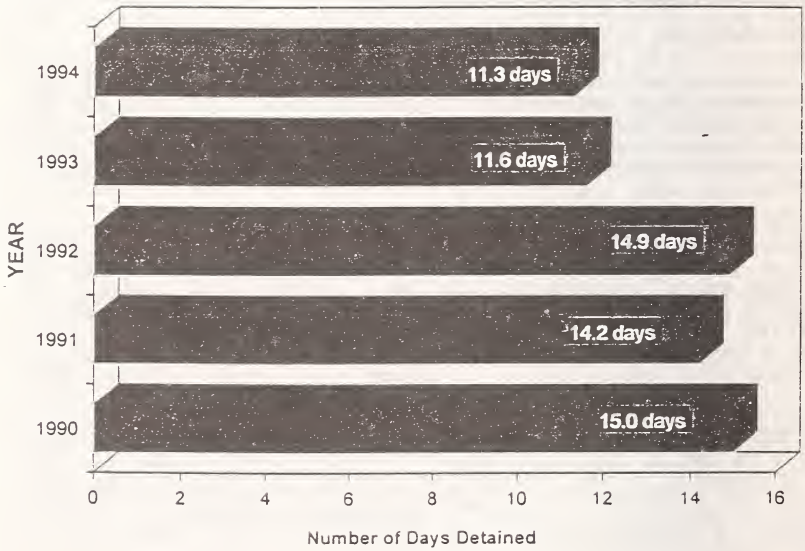
Mercy Health Plan Detained Baby Rate by Year—1990, 1991, 1992, 1993, 1994



Decrease in Average Length of Stay

The average length of stay for the detained babies is another way to evaluate WeeCare's program success. In 1990, the average length of stay for all of Mercy Health Plan's detained babies was 15.0 days. The ALOS dropped to 11.3 days in 1994. The ALOS for WeeCare intensively case managed babies who were detained in 1994 was 9.8 days.

Average Length of Stay for MHP Detained Babies By Year—1990, 1991, 1992, 1993



Successes in WeeCare Case Management

Those MHP members who were intensively case managed by the WeeCare staff experienced a much reduced detained baby rate when compared to other MHP members, who may or may not have been connected with another case management program. The chart below indicates that the more intensive intervention provided by WeeCare, the better the birth outcome of the infant. Those women who were case managed by a Healthy Beginnings Plus Provider (Medicaid funded case management program) experienced better birth outcomes in 1992 than in 1993, but still delivered healthier babies than women who could not be identified as having received

benefit of any case management. Women who were "unable to contact", we suspect, do not have a permanent residence and are therefore at a higher risk for poor birth outcomes. Those "lost to follow-up" were often suspected substance abusers.

WeeCare plans to interview several "unknown until delivery" members to determine how we could have identified them earlier. It is interesting to note that those who "declined to participate" have the best birth outcomes. These members generally have solid family support and easy access to medical care and do not require the services of WeeCare.

Total Detained Babies By Delivery Within Each Service Group—1992, 1993

Service Group	1992 Total Detained Babies by Service Group	1993 Total Detained Babies by Service Group
WeeCare Intensive Case Management (with home visits)	13.2%	13.2%
WeeCare Follow-Up (without home visit, member joined within eight weeks of delivery)	19.6%	15.4%
Healthy Beginnings Plus	12.4%	17.6%
Unable to Contact	22.6%	16.0%
Declined to Participate	12.3%	10.2%
Lost to Follow-Up	39.2%	20.8%
Unknown Until Delivery Date	25.8%	24.4%

Latest available figures for Service Groups

Program Cost Savings

WeeCare case managed babies who received a home visit and those WeeCare babies who were only case managed via telephone (without a home visit) have a blended detained baby rate of 14 percent (14.0%). Not only are these babies less likely to be detained, but when they are detained, they remain in the hospital for a shorter period of time.

The chart below compares the average length of stay (ALOS) of detained WeeCare case managed babies (both with and without a home visit) with those detained babies who were not case managed by WeeCare or Healthy Beginnings Plus.

Savings by WeeCare 1993

	ALOS	Cost/Baby
Detained babies case managed by WeeCare	9 days	$8,943
Detained babies not case managed by WeeCare or HBP	14.3 days	$16,520
Savings per detained infant	=	$7,577
Total savings attributed to WeeCare	=	$2,737,752

Latest available figures.

Costs per detained baby were determined by tabulating all of the claims MHP received for each detained baby. Clearly, the outreach efforts and case management activities invested in the early stages of pregnancy yield more positive and less expensive birth outcomes, even among those babies born too sick to return home with their mother.

Summary

Mercy Health Plan has taken the lead among other managed care providers in creating a program which aggressively seeks out pregnant women and connects those women to the resources that will support them throughout their pregnancy. Low income women may be most vulnerable to poor birth outcomes, but it is also clear that responding to pressing social and medical needs can help eliminate many of the obstacles disadvantaged women face when seeking health care.

For a woman living in poverty, providing transportation tokens or reimbursement for a baby-sitter may make the difference in whether prenatal care is received or postponed. Providing a home uterine monitor can make the difference between a preterm delivery and a baby born full term. Having the ability to select a private practice physician or a hospital based obstetrician for prenatal care may encourage a woman to seek care in a setting where she can best be served.

WeeCare is not a high-tech medical intervention. WeeCare is a high-tech human intervention. The challenge for a Medicaid managed care organization is to accept these circumstances and look for ways to practically intervene and support a member's efforts to obtain early prenatal care.

Mr. BILIRAKIS. Thank you, Ms. Stavisky. With the exception of the joint session that was held and we had that long, a little better than 2-hour break, we've been fortunate in that we haven't had a long series of votes, as we quite often do. But, unfortunately, that's long gone, because we have a 15-minute vote on the floor and, as I understand it, possibly another five 5-minute votes. So we're probably talking 40–45 minutes, at least.

I don't know what to do. You're busy people. You've been here all day long. But I don't really see any alternative other than to break and then we'll startup again right after the last vote. I'm just guessing about probably 3:15, maybe a little later. Three votes. I'm now told three votes in addition to the 15. So it's a little better. A 15-minute vote and then the three 5-minute votes.

Thank you so much. Appreciate your understanding.

[Brief recess.]

Mr. BILIRAKIS. Why don't we get started. The trouble with being toward the end is you lose your audience up here, as well as out there. Mr. Murray.

STATEMENT OF MICHAEL W. MURRAY

Mr. MURRAY. Thank you, Mr. Chairman, members of the committee. I want to thank you for the opportunity to be here today. My name is Michael Murray. I'm the Executive Director of the Health Plan of San Mateo. It's a county just south of San Francisco. If you've ever flown to San Francisco, you've landed in San Mateo County, just to give it a point of reference.

The health plan is a county-organized health system, also called a health insuring organization. It's created in Federal, State and county law. It began operation in December 1987 with about 27,000 members. It is the only Medicaid program in San Mateo County. We are currently at about 52,000 members.

There's a few things that make our plan somewhat unique from other managed care programs. First of all, it is truly a public partnership with the private sector; that is, it involves the county health department that contracts with us. They helped start the program. The hospital consortium, which represents all the hospitals in the county. The San Mateo County Medical Society were active sponsors in the program. And we have almost universal coverage for the Medicaid population; that is, we cover the aged, the blind, the disabled, the aid to families with dependent children.

We cover the undocumented individuals, foster care, people who are retroactively eligible. Oftentimes, we always we think of the prospective in most managed care, but we actually cover for people who become eligible after the fact. We're still responsible for that. And those elements make the program I think somewhat an advantage. We don't have marketing problems, but we do have the unique problems related to people with chronic illnesses and other related types of problems, such as AIDS. We cover transplants. So we have a bigger risk base.

In the process, I think we have demonstrated that we can do this successfully. From the point of view of access, when the health plan began, there were approximately two obstetricians, other than the county clinics, who would see new Medi-Cal. We now have con-

tracts involving over 60 obstetricians. They're now calling us saying where are all the patients. They want more.

We have primary care doctors, for adults in particular, that total over 230 total primaries. Many of these were not available prior to the health plan and the local involvement. We have the same network of providers that serve the commercial population, that are members of HMO's, also of indemnity programs or people who are self-pay. It's the same physician network because we use the Individual Practice Association model.

We've been very efficient, we believe, and we've kept high quality. We have a credentialing program, similar to what you hear from most HMO's. This is far greater than anything you'd find in the fee-for-service program. We conduct provider audits on a regular basis. Many of our providers said I've been serving the Medi-Cal population for over 30 years and never had the State in to audit. And we're in there every 2 years on our primary care providers and all our major specialists, we call them heavy hitters, we would see probably every 2 to 3 years.

What we've been able to do is to expand the scope of services. Those are some of the things I know you were interested in and we highlight some of those in our testimony. But we've provided a service, which I guess is best called well care for adults, which is not a Medi-Cal covered benefit. If you're healthy and you go to the doctor, Medi-Cal doesn't pay for it. If you're sick, it will pay for it.

We provide a HealthRide program, which originally was designed to help people who weren't able to have—their regular transportation failed; in other words, they ran out of money and couldn't take the bus or the grandmother or somebody who used to take them couldn't take them that day. We provided a taxi to make sure people got to their medical appointment, provide door-to-door service. We thought it was part of the reason for people not showing up for appointments.

As this program has evolved over 2 or 3 years, we find that it's not just that reason, but also many people who don't qualify for other means of door-to-door transportation—for example, wheelbound individuals, who have a program called Ready Wheels, and the public transportation provides that. We have people who have chronic illnesses that aren't wheelchair bound who don't qualify for those programs and it's very difficult for them, or for a mother with three children to transfer 2 or 3 buses to get to an appointment. We're providing those kinds of services through our enhancement money, our surplus savings.

And one other area to look at is the whole prenatal care program. I think you'll find in the testimony that we found some very striking stuff about the drop in baby days in the hospital. And one of these reasons, we think, is that for the undocumented individuals who are eligible for pregnancy services, which the State finances without Federal dollars, we have reduced their days dramatically for prematurity diagnosis and for complex deliveries. We believe our prenatal program is the primary reason for this.

We are now looking with the county, exploring long-term care, a supportive services project, where we will bring together community-based programs, long-term care service and acute care, which currently doesn't take place anywhere. We're trying to set that up

as another model as to how you combine the services and bring them together to meet the patients' needs, not just funding stream needs.

Thank you very much.

[The prepared statement and attachment of Michael W. Murray follows:]

PREPARED STATEMENT OF MICHAEL W. MURRAY, EXECUTIVE DIRECTOR, HEALTH PLAN OF SAN MATEO

Mr. Chairman, Members of the Committee, thank you for the opportunity to speak to you today about innovations in the Medicaid delivery system. My name is Michael Murray and I am the Executive Director of the Health Plan of San Mateo. San Mateo County, California is located immediately south of San Francisco. It is a county that is both urban and suburban, with a population of approximately 700,000. About 7.0% of the county's population is Medicaid eligible.

An Overview of the Health Plan of San Mateo

Medi-Cal is the California version of the federal Medicaid program. The Health Plan of San Mateo (HPSM or Health Plan) is an Independent Practice Association (IPA) model Medicaid managed health care plan that has been in existence since December of 1987. The Health Plan is a health insuring organization and county organized health system. By federal and state statute establishing the program, it is the only Medicaid health plan operating in San Mateo County. Membership as of December 1994 was approximately 52,000.

HPSM is unique in a number of ways. It is truly a community based, public/private partnership, supported by the county Health Services Agency, the local Hospital Consortium, the San Mateo County Medical Society, other providers and consumer advocates. As the sole Medicaid managed care plan in the county, HPSM provides essentially universal coverage for Medi-Cal beneficiaries. Unlike many other Medicaid managed care models, membership includes the AFDC population, SSI recipients and undocumented immigrants. HPSM's provider network includes any Medi-Cal provider certified by the state and meeting HPSM credentialing criteria. Contracting providers are part of the medical "mainstream"; most also participate in several commercial managed care networks.

HPSM is at full risk for the medical care provided to members. Again, unlike most other Medicaid and commercial managed care organizations, the Health Plan's financial obligation includes the medical expenses of both prospective enrollees and those members whose eligibility is known only retroactively.

HPSM is a primary care case management model in which members select or are assigned a Primary Care Physician (PCP) who authorizes inpatient care and some referral and specialty care. PCPs and hospitals are organized into physician-hospital risk pools that include hospitals in the Health Plan's risk-sharing arrangements. PCPs are paid a monthly capitation amount based on the age, sex and eligibility category of each of their enrollees. These payments are subject to a 15% withhold. Hospitals are paid a per diem by type of admission, also with a 15% withhold. Specialist are paid on a fee-for-service basis. Reimbursement to PCPs and physician specialists is at least 25% greater than Medi-Cal fee-for-service rates. PCPs are at risk for primary care, specialty care and pharmaceuticals. The risk for inpatient care is split between PCPs and the hospitals. Deficits in the risk pools are funded by the PCP and hospital withholds, with the Health Plan at risk should the deficit exceed the 15% withhold. Surplus payments are shared among the PCPs, hospitals and the Health Plan.

The Health Plan of San Mateo has been financially successful, distributing withhold and surplus dollars to providers in each year of its operation and using savings to finance program enhancements that are not part of fee-for-service Medi-Cal coverage.

A profile of HPSM's membership and provider networks follows:

HEALTH PLAN OF SAN MATEO—Membership Profile
[Number of Members—52,000 (December 1994)]

Gender:	
Male	39.0%
Female	61.0%
	100.0%
Age:	
0-4	17.9%
5-19	27.3%
20-44	24.2%
45-64	8.2%
65-84	19.2%
85+	3.2%
	100.0%
Medicaid Eligibility:	
Low-Income Families	52.9%
Aged	18.8%
Blind/Disabled	18.2%
Medically Indigent Children	6.7%
Undocumented Immigrants	3.0%
Medically Indigent Adults and Refugees	0.4%
	100.0%
Ethnicity:	
Hispanic	32.7%
Caucasian	28.7%
African/American	15.9%
Asian/Pacific Islander	8.6%
Other/Not Reported	15.0%
	100.0%

Provider Network Profile—(May 1995)

Primary Care Physicians	162 contracts representing 234 PCPs
Referral Physicians	300 contracts representing specialty physicians in solo, group, clinic and university practices
Hospitals	12 contracted facilities in San Mateo, Santa Clara and San Francisco counties
Pharmacies	114 contracts representing independent pharmacies and chains with multiple sites
Other Services	240 contracts covering non-physician providers

Access to Medical Care for HPSM Members

Perhaps HPSM's most stunning impact in the community has been the improvement in access to health care providers for Medi-Cal beneficiaries. Prior to its December 1, 1987 start date, the Health Plan had determined that only two private obstetricians, aside from the county Health Department, and approximately 20 PCPs were accepting new Medi-Cal patients on self-referral. There are currently 65 obstetricians and over 230 PCPs available to see HPSM members. In addition, the Health Plan maintains 350 referral contracts, representing specialty physicians in solo, group, clinic and university practices; 12 hospital contracts in San Mateo, Santa Clara and San Francisco counties; 114 pharmacy contracts representing independent pharmacies and chains with multiple sites; and 240 contracts with non-physician providers.

How HPSM Receives and Allocates its Funds

HPSM contracts with the State of California to administer the Medi-Cal program in San Mateo County. HPSM's operating revenues come from capitation payments received from the state, augmented by related interest earnings. The rates paid to the Health Plan have ranged from 95% to 99% of the fee-for-service equivalent, assuring the state up-front savings over the cost of the traditional fee-for-service Medi-Cal program, while HPSM assumes full financial risk for the delivery of care.

HPSM's expenses are either health care or administrative costs. Health care expenses comprise 92% of total expenses, and consist of primary care physician capitation payments (plus the withhold), inpatient hospital reimbursement (plus the with-

hold), medical expenses (including referral physician, ancillary, hospital outpatient and patient transportation services), and pharmacy expenses. Administrative expenses comprise 8% of total expenses.

HPSM Program Enhancements

As a prepaid managed care plan, HPSM has the flexibility to use its revenues and savings in ways not possible in the traditional fee-for-service Medicaid system. Innovative program enhancements implemented by HPSM include the Prenatal Care Program and Comprehensive Perinatal Services Grant Program (described below), HealthRide (for transportation to medical appointments when the member's usual means of transportation is not available), Adult Preventive Health Screenings (not a covered Medi-Cal benefit in the fee-for-service system), an Expanded Drug Formulary and the Comprehensive AIDS Services Program.

HPSM's Prenatal Care Program

HPSM began its special Prenatal Care Program in 1990. The goal of the program is to decrease the incidence of low-birthweight newborns and premature labor among Health Plan members and increase the general health status of the mothers and babies. The Prenatal Care Program helps pregnant women access early and regular prenatal care, assists them with problems presenting barriers to maintaining care, and facilitates participation in community programs such as low-cost childbirth education classes. *The main components of the program are increased reimbursement rates and improved support to obstetrical providers, incentives for members to get into care early and keep appointments, personal and professional advocacy by the HPSM staff on behalf of members, and promotion of the program to beneficiaries.*

HPSM's 1994 report on this program is attached.

Since the Health Plan began its multi-faceted prenatal program, marked improvements have taken place. The number of obstetrical providers serving HPSM members increased by about 30%. The percentage of women starting prenatal care in the first four (4) months of pregnancy has increased by about 15% while the percentage starting care in the last trimester has decreased by nearly one third.

The impact of increased access and improved rates of prenatal care can be seen in a significant reduction in the length of stay for newborns, primarily as a result of a dramatic reduction of days associated with prematurity and complex deliveries. The rate of hospital days per 1,000 for prematurity has been reduced by 55%. For all complex delivery diagnoses, the rate has been reduced by approximately 30%. In addition, the percentage of C-Section deliveries has continued to decrease and stands at about 14.6%. As a result of these changes, the overall length of stay for newborns in hospitals has decreased by over 35% with no apparent negative impact on patient care. In addition to the advantages of faster family bonding and less risk of hospital caused infections resulting from this reduction in patient days, the Health Plan has experienced substantial financial savings which have been reallocated to more cost effective health care services for members.

HEALTH PLAN OF SAN MATEO

Update on Prenatal Care Promotion Program - 9/94

The Health Plan of San Mateo (HPSM) began a special prenatal care promotion program in the county to increase access to obstetrical care for Plan members. The promotion program, begun in late 1990, has been successful due to five key factors - the five "Ps" of prenatal care promotion.

The five "Ps" are as follows:

- Planning the program
- Provider incentives - increased rates and support - money talks
- Promotion of the program to beneficiaries
- Prenatal care incentives - reward for getting into care early and keeping appointments
- Personal and professional advocacy by the staff on behalf of members

The key contributors to the success of the program were the increased rates to providers and the promotional efforts by the staff to inform members of their opportunities.

Provider Rates

The increase in the global and delivery fees contributed substantially to access. The provider rate comparisons are displayed in the table below:

A Comparison of the Number of OB Providers and Reimbursement Rates Between the Health Plan of San Mateo and the Medi-Cal Fee-for- Service System - 1989-1992

	12/1/89	12/1/90	12/1/91	12/1/92
# OB Contracts	31*	32	38	44
# OB Providers	47	48	55	60
Global State Fee-for-Service Rate	$961.20	$961.20	$961.20	$961.20
Delivery FFS Rate	$480.60	$480	$480	$480
Ultrasound	N/A	N/A	$90	$90
Plan Global Fee	$961.60	$1,400	$1,450	$1,450
Plan Delivery	$480.60	$700	$725	$725
Plan Ultrasound	N/A	N/A	$90	$90

*Includes 1/3 contracts accepting unlimited referrals and 2/3 contracts with limitations.

Of particular note is the predominance of individual/group private practice physicians providing care to Plan members. (See Appendix 4 - List of Prenatal Care Providers which is given to the members.) The few San Mateo traditional, safety net providers have been contracted providers since the beginning of the Plan. The general medical community serving Plan members is the same as the medical community contracting with other

commercial, managed care plans. This "mainstream" thrust has been a predominant message to members since the Plan's inception.

Additional Provider Incentives - Comprehensive Perinatal Services Program Grants

The Plan **also provided start up grants to hospitals and group and/or individual medical providers** to establish the **Comprehensive Perinatal Services Program (CPSP)**. The hospital group providers and individual physicians or groups applied for grants from a $500,000 allocation of surplus or enhancement funds acquired through the management of the total program over time. The grants were awarded according to the number of deliveries rendered by the individual physicians during the previous budget year.

Promotional Activities

Promotional efforts by the staff and community health care agencies continue to include the following activities:

- Member Services Representatives explain the program and take initial applications for the incentive program at their regular weekly intake meetings, located at the 5 Human Service Agency sites in the county.

- Member Services Representatives distribute brochures and explain the program in their various community organization and agency visits throughout the county, e.g. homeless shelters, group homes, community referral groups, street and health fairs, etc. The prenatal care promotion staff also provides information to members of the San Mateo County Perinatal Council at their regular meetings.

- Staff in the various social service and health care agencies refer women to the Plan.

- Physicians and their staffs also refer the women.

- The Prenatal Care Promotion staff contacts doctors' offices to inform them about the program, how it works, what the doctor's office needs to do to verify the appointments, etc.

- When the program began, the Plan "piggybacked" the state-wide media promotion of early prenatal care that was occurring. The current state-wide toll-free number tape refers callers to their local health departments. Very few of the Plan members have been prompted to look for prenatal care in the county as a result of the tape message.

- The Plan inserts special promotional flyers in its monthly mailing to new members.

- The program is described in the Member Handbook.

- The Plan provides check inserts about the prenatal care incentive program to the San Mateo Human Service Agency. These inserts are included quarterly in the AFDC check envelopes distributed by the local income maintenance agency.

- The attached brochure (Appendix 4), listing the OB providers and details about their offices, is included with the Medi-Cal and AFDC applications at intake interviews at the San Mateo County Human Service Agency (county social services). Because OB services do not require an authorization from a Primary Care Physician, the women can choose a provider from the list and proceed to the doctor's office. Hence the list is distributed to applicants for Medi-Cal and AFDC as well as to members of the Plan.

- HPSM promotes use of the prenatal care program through the Mother's Helper Line, which is the identifier for contact with the prenatal care staff. Telephone numbers are the HPSM main and toll-free numbers.

Member Incentives to Encourage Early Care

The incentives provide stimulation to members to get early care. Three incentives are awarded as follows:

- Following verification of the first appointment with the prenatal care provider, which may occur at any time in the pregnancy, the women receive a **colorful, informative prenatal care calendar in English or Spanish.**

- At the end of four months of prenatal care appointments verified by the provider, **they receive a $40 gift certificate at Safeway** - good for anything except cigarettes, alcohol or cash return. Safeway contributes 8% to the gift certificate from their community service program.

- At the end of seven months of care, usually just prior to the delivery, the women receive a **$50 Geoffrey gift certificate at Toys 'R Us to be used for car seat, stroller or any other items the mother desires.**

  Originally the Plan purchased and distributed car seats and strollers directly to the members. When the volume of incentives and subsequent staff time consumption became unmanageable, the Plan decided to purchase the Geoffrey dollars. The Plan staff was reluctant to give up the direct distribution of the third incentive, but efficiency and resource commitment required a change in the process. Members like the flexibility and convenience this choice offers.

Initial Planning and Continuing Coordination

The **initial planning** for the program included coordination with all of the participating sectors - eligibility agencies, prenatal care providers, hospitals, Plan advisory groups, community agencies, public health staff and the HPSM staff. Implementation planning included training sessions for providers, distribution of printed materials to providers, community agency education and the local Human Service Agency sites.

Continuing coordination and coalition building continues to support the outreach efforts. The HPSM Health Promotion Manager was instrumental in the founding of the San Mateo County Perinatal Council. Plan prenatal care staff members are active in the council and use it as a way to communicate with prenatal care providers and interest groups. Coordination with specific San Mateo County Health Department programs - the Prenatal Advantage Program, a special project for African American women, and the Women, Infants and

Children Nutrition Program (WIC) - provide additional resources which support the women in their prenatal care period.

Personal Support and Advocacy

Prenatal care promotion staff provides **personal support and advocacy** for the women with the providers when problems arise. The problems include various issues as follows:

- the inability of the woman to communicate with her provider,
- reluctant acceptance by the provider of choice due to high risk maternal health conditions which are not necessarily associated with the poverty,
- multiple births,
- previous delivery histories,
- the need to change providers for various reasons, and
- the late stage of the pregnancy, which may be contingent on how rapidly her Medi-Cal application was processed, in addition to her own procrastination or a number of other factors.

Delay Factors in Getting Care

Factors contributing to the delays in getting care reported in the literature appear to be common to the Plan population as well. These factors are primarily the lack of insurance, money, and Medi-Cal - and the woman's level of acceptance of or indecision about the pregnancy. Approximately 13-15% of the women have reported the delay in applying for Medi-Cal was due to the lack of information or no receipt of their Medi-Cal "stickers". During the last two years none of the women have reported delaying getting care due to the lack of an available OB provider. Approximately 10% of the women who delay getting care report the delay was initially due to the lack of transportation.

Transportation

The Plan has offered **transportation to regularly scheduled medical appointments** for Plan members whose usual form of transportation has failed. Pregnant members learn about the HealthRide transportation as part of their intake presentation. Once they are Plan members, lack of transportation for the women is not a problem.

Impact of Federal and State Policy changes - Presumptive Eligibility

The most recent state policy to encourage early prenatal care - presumptive eligibility - has generated very few "unknown" applications and subsequent enrollments. **The presumptive eligibility aid codes are not currently included in the Plan's contract** with the Department of Health Services.

Impact of Federal and State Policy Changes - Addition of IRCA/OBRAs

IRCA/OBRAs, the primarily undocumented women who receive prenatal care as a result of

the Omnibus Budget Reconciliation and Immigration Amnesty Acts, did not have access to many of the Plan providers and the incentive program **until September 1993 when these beneficiaries were included in the Plan's contract with the Department of Health Services.** These restricted category members have full access to the OB services of the Plan. The attached reports reflect the differences between the pre IRCA/OBRA enrollment and their inclusion. The prenatal care utilization by this population is almost equal to the utilization by the full scope members of the Plan. Nearly half of the total enrollees in the incentive program are IRCA/OBRA eligibles, 99+% of whom are Latinas.

Impact of Federal and State Policy Changes - Status of "Bergesons" - Percent of Poverty Beneficiaries

Remaining outside of the Plan are the women and children in the 133%, 185% and 200% of poverty categories - the "Bergesons", named for California's Senator Bergeson who sponsored the state legislation to cover their prenatal care. The Plan has requested that the California Department of Health Services include this population in the contract. As of the end of FY 1993-1994 the "Bergesons" remain outside of the Plan. They may be included in the new contract beginning December 1994. Payment and continuity of care situations for this population become complicated when the women's incomes are variable. They move back and forth between Plan membership and non-Plan membership as their eligibility is affected by their incomes. Providers, some of whom take only Plan members, are caught in the middle because they are required to bill the state at the state rate for care for the women who may have begun their pregnancies as Plan members but who finished the prenatal care period as Bergeson eligibles.

Program Staffing

Initially the prenatal care promotion program was staffed with 1 FTE. In 1993 .5 FTE was added to the program . This staff communicates with members primarily through the telephone. Member Services Representatives primarily have the direct personal contact with the women. When HPSM was distributing the car seats/strollers to the women directly, prenatal care staff would have at least one face-to-face contact with the women.

Program Evaluation

The first two years of the prenatal care promotion program are currently being evaluated through a contract with Paula Braveman, M.D., Department of Family and Community Medicine, University of California at San Francisco The evaluation includes analysis of the birth certificate data from the state/county systems of San Mateo and Santa Clara. Stanford Hospital, one of the contracting providers, is located in Santa Clara County. Deliveries at contracting hospitals in San Francisco are included with the San Mateo data.

The Plan has provided delivery claims data from the Plan's payment system and enrollment data from the prenatal care promotion program data base to the evaluator for further comparisons. A copy of the prenatal care database record, maintained in PC software, is attached to this report. Member identification data is downloaded to the PC file from the Plan's AMISYS system.

Member Satisfaction Surveys

Plan staff also have mailed post-service individual satisfaction surveys to the women who enrolled in the incentive program. Members have commented on how well the specific physician/nurse treats them and on the attitudes of the receptionist/support staffs. Members have responded more favorably when they felt that they could talk with the provider and the providers listened to them.

Current Activity

What's happening now?

- The prenatal care promotion staff is revising the management of their telephone enrollment process and other ways to inform members about the incentive program and the importance of prenatal care. The process begins with a meeting with the Member Services Representatives about their experiences in communicating with members on a regular basis.

- The rates adopted in 1992 remain the same and the OB access is good. Providers frequently call to ask for more referrals.

- The Plan will evaluate the CPSP program this year for its effectiveness in providing the information to women. CPSP services - individual personal assessment of needs during the pregnancy and the provision of individual and group counseling in health education, nutrition and prenatal care - are delivered by a range of methods and staff combinations. Some physicians provide all of the information directly. Others use mid-level staff or contract for the nutrition counseling. HPSM application of the state policy has encompassed the full range of possibilies.

  CPSP providers are authorized by the Maternal and Child Health Division of the San Mateo County Health Services Agency and the California Department of Health Services. HPSM reimburses the contracting providers for the specified services through the usual payment system

- The promotional methods continue with the assistance of Member Services, the providers, community organizations and the Human Services Agency.

Statistical Reports

Member Services staff and the Prenatal Care Promotion staff track their contacts with the women. Attached are reports with data from the program years of 1991-1992, 1992-1993 and 1994 which provide some simple comparisons of the growth of the Plan and the enrollment in the incentive program. The data also provides some comparisons of the stages of pregnancy at the Medi-Cal application period and the pregnancy stage when the individual is referred to the incentive program.

Appendix

1. Annual Statistical Data from Member Services
2. Annual Statistical Data from the Prenatal Care Program Enrollment
3. Prenatal Care Data Base Case Sheet
4. Prenatal Care Provider List
5. Information Sheet - Health Plan of San Mateo

MEMBER SERVICES
A. PRENATAL CARE OUTREACH BASELINE DATA

	A	B	C	D	E	F	G	H
Health Plan of of San Mateo Fiscal Year (December 1 to November 30)	Total Pregnant Women Attending Intake Presentations	Total Pregnant Women Receiving Care When Attending Intake Presentation	Percent of All Women Receiving Care At Intake	Four Months Pregnant or Less Receiving Care (In Percent)	Percent In Last Trimester	Eligibility Status of Women When Attending Presentations		
						Number of Plan Members	Other Eligibles	Applicants and Others
1990 - 1991	867	483	55.7%	204 (42.2%)	120 (28.4%)	184 (22.8%)	297 (36.8%)	326 (40.4%)
1991 - 1992	1,056	644	61.0%	312 (48.4%)	151 (23.4%)	233 (22.1%)	508 (48.1%)	315 (29.8%)
1992 - 1993	1,209	834	69.0%	357 (42.8%)	254 (29.4%)	390 (32.3%)	596 (42.3%)	223 (18.4%)
1993 - 1994 (Year-To-Date)	1,122	881	78.3%	452 (47.5%)	163 (18.4%)	817 (72.5%)	92 (11.4%)	208 (18.9%)

EXPLANATIONS:

A. All women attending the intake presentation.
B. Total of pregnant women in prenatal care when they attend intake session.
C. B/A - Percent of women receiving prenatal care at intake.
D. Percent of women by each month who were pregnant 4 months or less and receiving prenatal care at intake presentation; subset of C.
E. Percent of women each month who were in last trimester and receiving care at intake; subset of C.
F. Number of Plan members attending intake session.
G. Other eligibles - intercounty transfers, those with other insurance coverage, IRCA/OBRA and Bergesons.
   * As of 9/93 IRCA/OBRAs became Plan members and other eligibles became exclusively the Bergesons.
H. All applicants pending decision of eligibility - Plan, IRCA/OBRA and Bergesons.

Appendix 2

YEAR TO DATE PRENATAL CARE OUTREACH DATA

DESCRIPTION	1991–1992 TOTAL	%	1992–1993 TOTAL	%	* 1993 – 1994 TOTAL	%
Participation Status						
Monthly Enrollments **	494		717		322	
Active Cases During the Year ***	280		311		468	
REPORTED SINGLETON BIRTHS						
Over 5.5 lbs.	183	97.9%	292	96.0%	115	95.0%
Below 5.5. lbs.	4	2.1%	13	4.0%	6	5.0%
REPORTED MULTIPLE BIRTH SETS	N/A		N/A			
Over 5.5 lbs.					1	50.0%
Below 5.5. lbs.					1	50.0%
ALREADY IN CARE @ TIME OF ENROLLMENT	162	33.0%	535	74.6%	251	78.0%
STAGE OF PREGNANCY AT REFERRAL TO PRENATAL CARE ASST						
No. of Months						
2	115	16.3%	61	8.5%	23	7.0%
3	121	17.1%	97	13.5%	19	6.0%
4	98	13.9%	102	14.2%	34	11.0%
5	92	13.0%	87	12.1%	38	12.0%
6	68	9.6%	95	13.2%	34	11.0%
7	69	9.8%	80	11.3%	41	13.0%
8	73	10.3%	59	8.2%	50	16.0%
9	53	7.5%	114	15.9%	43	13.0%
Unknown	18	2.5%	22	3.1%	40	12.0%
INCENTIVES AWARDED						
Initial Calendar	323		474		121	
4 Months (Grocery Cert.)	233		480		105	
Car Seat/Stroller (7 mos)	132		261		45	
Geoffrey Dollars (7 mos)	N/A		N/A		3	
REFERRED FROM						
Doctor's Office	124	17.8%	121	16.9%	38	12.0%
Public Health	1	0.1%	4	0.6%	1	0.3%
Member Services Reps	224	32.2%	201	28.0%	115	36.0%
Eligibility Workers	59	8.5%	67	9.3%	17	5.0%
Planned Parenthood	29	4.5%	8	1.1%	2	1.0%
Hospitals	70	10.1%	39	5.4%	7	2.0%
Community Agencies/ Presentations	43	6.2%	48	6.7%	30	9.0%
Member Newsletter/ Check Enclosures	91	13.1%	50	7.0%	4	1.0%
Other	54	7.8%	179	25.0%	74	23.0%
Unknown	0	0.0%	0	0.0%	34	11.0%

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* December 1993 through April 1994

** Monthly enrollments – newly enrolled in incentive program by the month the women enrolled

*** Unduplicated count of total number of women in the program during the fiscal year (December 1 through November 30)

DESCRIPTION	1991–1992 TOTAL	1991–1992 %	1992–1993 TOTAL	1992–1993 %	1993 – 1994 TOTAL	1993 – 1994 %
WOMEN'S AGES						
12 – 15	12	1.7%	19	2.6%	5	2.0%
16 – 20	173	24.5%	200	27.9%	76	24.0%
21 – 25	234	33.1%	216	30.1%	105	33.0%
26 – 30	151	21.4%	107	14.9%	53	16.0%
31 – 35	92	13.0%	106	14.8%	37	11.0%
36 – 45	37	5.2%	56	7.8%	21	7.0%
Unknown	8	1.1%	13	18.0%	25	8.0%
ETHNIC BACKGROUND						
White			145	20.3%	38	12.0%
Black			138	19.2%	37	11.0%
Hispanic			278	38.8%	193	60.0%
Middle Eastern			21	2.9%	6	2.0%
Filipino			43	6.0%	14	4.0%
Pacific Islander			22	3.1%	9	3.0%
Asian			16	2.2%	2	1.0%
Other			51	7.1%	9	3.0%
Unknown			3	0.4%	14	4.0%
Number of Children						
0					122	38.0%
1					81	25.0%
2					48	15.0%
3					22	7.0%
4					12	4.0%
Over 4					8	2.0%
Unknown					29	9.0%
Highest Grade Level Completed						
Under 9th Grade					87	40.0%
9					20	9.0%
10					19	9.0%
11					0	0.0%
12					94	43.0%
Over 12th Grade					47	23.0%
Unknown						

Mr. BILIRAKIS. Thank you so much, Mr. Murray. Ms. Bluestone.

STATEMENT OF MAURA BLUESTONE

Ms. BLUESTONE. Thank you. My name is Maura Bluestone. I'm the President and the Chief Executive of the Bronx Health Plan. The Bronx Health is a not-for-profit HMO in New York City which was designed specifically to serve Medicaid clients and other low income populations. We have two programs for uninsured clients, as well.

We're in our ninth year of operation. We currently have about 42,000 members in total, 35,000 of whom are Medicaid recipients on public assistance, all of whom joined this plan voluntarily. We provide all covered services through arrangements with community-based providers, including over 200 primary care providers practicing in 18 health centers throughout the Bronx and northern Manhattan.

I think it's very important we always keep in mind that when we're bringing managed care into the Medicaid population, introducing it into the Medicaid program, we're really doing a lot more than just introducing a different financing mechanism. We're doing more than just paying for services in a different way. We're really trying to change the health care system itself. We're introducing a whole new set of priorities for clients, as well as the providers. We're trying to change their expectations, their behaviors, and the very culture of care-giving and care-seeking which prevails in the conventional Medicaid program.

I think there are a lot of ingredients that are critical to the success of Medicaid managed care and I wanted to take the few minutes I have today to highlight two pieces, two ingredients that I think are very critical. One of them is the member services component of Medicaid managed care and the second one is the provider relations component. We all know that client education is really critical to Medicaid managed care. It's also a very sensitive issue.

We want to make sure that clients have made an informed choice when they join the plan. We want to know they understand the program, what is expected of them, what they can expect of us, and how they can use the services to their own benefit. And so to respond to that need, we at the Bronx Health Plan have really invested very heavily in our member services department. We staff it very heavily. Our member services department is staffed at approximately one staff member for every 3,000 clients.

And in addition to kind of the conventional member services, we do a number of types of activities. I wanted to highlight a few of them which I think make a big difference in reaching out to this population and engaging them in this new system of care.

One of them is, like all plans, we send our written information, but it's not just the standard member handbook. We also send out a lot of information about the health center they chose, where it's located, public transportation to that health center, where the pharmacies are in their neighborhood, lots of information to try and make sure they have stuff at their fingertips.

Second, we place a welcome call to every new member who has a phone. Only about half of our members have phones. But we reach out, make that welcome call right near the beginning of their

membership to once again remind them about the program, go over some of the basic features with them. We conduct orientation sessions at our health centers. So they can also see the facilities and learn how to use them. But in addition, we've just recently started doing special orientation sessions for folks who come to us with chronic or other types of preexisting conditions, where we focus the orientation very specifically to make sure we get them linked to primary and specialty care right away.

We do follow-up calls of emergency room visits and emergency admissions. And the major purpose there is not to tell someone they did something wrong if they were there inappropriately, but to basically go back over again what really constitutes a true emergency—a lot of people have a different concept than we might about what constitutes an emergency—and what their alternatives are that we're encouraging them to use instead of the ER.

We also do something that most insurance companies wouldn't do. We actually go through our files, identify who has not been using services and we call them and try and find out why haven't you been using services and encourage them to come on in and at least get engaged in preventive care.

Those are just a few of the things we do with clients, members, but we also look at providers as a very important customer in this program. We're really trying to get the providers and the members here, the Medicaid clients, together working constructively in a new type of patient care relationship. So we also invest very heavily in our provider relations activities; not just the recruiting and credentialing that are typical in provider relations, but we actually provide staff who go out at least once a week, if not more often, into those sites and really establish, almost like an account rep, an opportunity to interact with the providers, help them make best use of the program.

We also do very intensive orientations for the providers, not just the clinicians, but their office staff, as well, make sure that everybody understands what this program is about and how to approach our clients.

I want to close by mentioning that there are many things that we've outlined, a number of them, in the testimony. They're not real sophisticated. They're not high tech. They really just require a lot of good interpersonal human skills and an attitude of personal service that reaches out to a clientele and a provider community who we're expecting to change in some very significant ways, and I think it is critical that those ingredients be built into these programs.

I encourage you to look for other models of that and perhaps think about those kinds of elements when you set standards and monitor performance of Medicaid managed care.

[The prepared statement of Maura Bluestone follows:]

PREPARED STATEMENT OF MAURA BLUESTONE, PRESIDENT AND CEO, THE BRONX HEALTH PLAN

Mr. Chairman and members of the Committee, my name is Maura Bluestone. I am the President and Chief Executive Officer of The Bronx Health Plan, a not-for-profit HMO in New York City which is designed specifically to serve Medicaid clients and other low-income, inner city populations.

The Bronx Health Plan is in its ninth year of operation. We currently serve close to 42,000 Members, over 35,000 of whom are Medicaid recipients. The balance of our membership, close to 6,000 people, is enrolled in premium-subsidized coverage programs for low-income, uninsured individuals and families.

The Bronx Health Plan is a network model HMO. We do not deliver services directly; rather, we arrange for the delivery of services through contracts with a wide variety of community-based providers.

Our network of primary care providers is composed of over 200 clinicians practicing in 18 community health centers located in the Bronx and northern Manhattan. Specialty referral services are provided through our network of about 800 physicians covering all specialty and sub-specialty disciplines. In addition, we have contracts with area hospitals, pharmacies, home health agencies, mental health and substance abuse services, transportation services, and a variety of other providers and vendors needed to cover our comprehensive benefit packages.

I understand that many questions and concerns have been raised about HMOs generally, and, specifically, about HMOs which serve Medicaid recipients. As in any industry, there are good players and bad players, effective companies and ineffective companies, successful enterprises and unsuccessful ones. I am here today to tell you that the same is true in the Medicaid managed care industry...but even though there are some problematic situations which gain media and political attention, there are many success stories as well. I would like to take this time to describe two ingredients of The Bronx Health Plan which I believe are keys to success in serving Medicaid managed care clients. These ingredients—extensive member services and provider relations activities—focus on the needs and expectations of care-seekers and care-givers.

We like to look at the health plan as a matchmaker. Our role is to bring patients and providers together so that they can form continuing, personal service relationships. We, the health plan, also bring financial resources and a variety of service arrangements to the table so that the providers and patients in our Health Plan have a rich array of services from which to choose in seeking the most appropriate care.

As we all know, the conventional system of care for Medicaid recipients is often fragmented, impersonal and of questionable quality. When we set out to build The Bronx Health Plan, we were intent on changing that inadequate system of care. To accomplish this mission, it was important for us to understand the needs and expectations of providers as well as consumers. We understood that when we introduced managed care into the Medicaid program, we were not just changing the way in which we pay for services. Rather, we were changing the service delivery system; we were introducing a new set of priorities, we were trying to change expectations, behaviors, and the culture of care-giving and care-seeking which prevail in the conventional Medicaid system.

I am proud to say that we have had a lot of success in this area, and much of it can be traced to the two ingredients which I mentioned earlier—member services and provider relations activities.

Client education is a critical and sensitive issue in Medicaid managed care. We all want clients to make an informed choice when they join a managed care plan. We want them to understand how the program works, what is expected of them, and how to make best use of the services offered. Believe me, this level of understanding does not happen—either in a commercial or a Medicaid population—as a result of a marketing presentation and the reading of Member Handbooks and other health plan literature. No, that understanding only emerges as a client uses the system, and constantly hears the same messages.

With this in mind, The Bronx Health Plan provides a rich staff-to-client ratio in our Member Services Department, the equivalent of about one staff person for every 3,000 Members. As in most plans, this staff handles Member complaints, inquiries, and problems. In addition, however, we have a number of activities which all focus on engaging the client in our system of care.

Let me give some examples.

1. Just prior to their effective date of enrollment, each new Member receives a package of materials, including a fact sheet on the health center they selected as their primary care site, public transportation routes serving their health center location, instructions on how to contact and register at their health center, a list of participating pharmacies in their neighborhood, and other information introducing them to the Health Plan and its services.

2. Each new Member who has a telephone (approximately 50% of our Membership) receives a "Welcome Call" from one of our Member Services Representative within the first two weeks of enrollment. The purpose of the Call is to review major

features of the Health Plan, and, specifically, to remind them about how to use their primary care health center.

3. Our staff conduct orientation sessions for new Members at the participating health centers, so that these Members can not only become familiar with the health center, but can also be reminded about Health Plan policies and procedures for accessing services appropriately.

4. We hold special orientation sessions for new Members who report pre-existing conditions or on-going medical concerns. The purpose of these sessions is to pay special attention to the need to link these Members with appropriate primary and specialty care services within our network.

5. We either call or write Members shortly after an emergency room visit to discuss the reason they sought emergency room care, and, if appropriate, to discuss the definition of what constitutes a "true" emergency, and to reinforce the message that they should use alternative services for non-emergent conditions.

6. Similarly, we either call or write Members following an emergency hospital admission to, once again, review the circumstances and, if appropriate, counsel them on more appropriate care-seeking decisions.

7. We also do something I suspect most, if not all, insurance companies wouldn't think of doing—we periodically review our data to identify Members who, after six months of enrollment, have not used any covered services. We then call them to encourage them to contact their primary care provider, to make an appointment for a physical exam, and to seek at least some preventive and health promotion services within our system.

8. We staff our Member Services Department from 8:00 in the morning to 8:00 at night all weekdays, and we have Member Services staff on call around the clock to respond to Members problems and concerns. In addition to staff in our corporate offices, we deploy Member Services Representatives to our participating provider sites to facilitate access of our Members to our customer relations services.

9. We also have an extremely active Member Advisory Board which now has around 30 Members who meet, without fail, once each month. This group not only gives our staff advice and comments on the program, the providers and life in general, but also gives us a sounding board against which to reality-test some of our ideas and materials. For example, the Member Advisory Board reviews our draft Member survey questionnaires, handbooks and brochures, and lets us know if we are addressing relevant concerns, using appropriate vocabulary, or, in general, communicating effectively.

10. As an off-shoot of the Member Advisory Board, we have a program called "Staff for a Day" in which individual Members spend a day with one of our staff. It's a great way to make sure that the Members are not anonymous, faceless clients to our staff, and, conversely, that our staff are not anonymous, faceless bureaucrats to our Members.

These are but a few examples of the types of initiatives undertaken in our Member Services Department. All of these activities emphasize the importance of personal service, and they all focus on understanding the needs and expectations of our clients so that our managed care plan can be as responsive to those needs as possible.

Our enrolled Members, however, are not our only clients. We also look upon our participating providers as our important customers who, like the Members, need to be oriented, educated and served by the Health Plan.

Our Provider Relations activities, therefore, focus on making the Health Plan as user-friendly as possible for the providers, and on helping them serve the Members most effectively.

Some examples of our Provider Relations activities include the following.

1. Our staff conduct a series of intensive orientation sessions during the few weeks leading up to the implementation of our program in a given provider site. Our orientations focus not just on the doctors, but, very importantly, on the nursing and administrative staff as well. As we all know from our personal experience as patients, the quality of care begins with the front office staff—the receptionist, the appointment clerk, the intake nurse, etc. Without their understanding and cooperation, our system of care really can't work well for Members or providers.

2. We assign a Provider Relations Representative to each primary care provider site. That Representative frequently visits the site to check up on how things are going, to bring information to the providers, and to listen to their concerns. We are partners in this enterprise, not adversaries.

3. We prepare and produce materials that providers can use in their facilities—posters, informational brochures, etc.—to give clients information about the health plan.

4. In addition to Member Satisfaction Surveys, we conduct periodic Provider Satisfaction Surveys, and we use the results to focus our Provider Relations efforts.

As with Member Services, our Provider Relations activities are designed to build and nurture the personal relationships which assure that our managed care plan is truly addressing the needs and expectations of clients and providers.

As you can see, none of the activities which I have described here are terribly sophisticated. They don't require high-tech applications or highly-trained staff. But they are incredibly effective means to assure that the managed care plan is a provider of personal services which are sensitive to the diverse and often complex needs of its Members.

The Bronx Health Plan, and many other HMOs and managed care plans, have demonstrated the ability to provide high quality, responsive services to Medicaid clients. Unfortunately, however, it is often only the bad stories and occasional scandals which draw attention. I thank you for the opportunity to share some of our success story with you today. I also urge you to continue to seek out the successful programs, and hold them up as models on which to set standards and monitor performance.

Mr. BILIRAKIS. Thank you, Ms. Bluestone. Another fine story that we're hearing from this panel. Dr. Jampol.

STATEMENT OF JESSE JAMPOL

Mr. JAMPOL. Mr. Chairman, I'm Dr. Jesse Jampol, medical consultant and retired medical director of the Health Insurance Plan of Greater New York, a not-for-profit prepaid group practice model health maintenance organization operating in New York, New Jersey, and affiliations with an HMO in Florida.

I was a practicing physician in the HIP system for over 32 years and then served as medical director for the entire plan for 6 more years. In my capacity as medical director, one of my responsibilities was oversight of the HIP Medicaid program.

I'd like to share with you nearly 30 years of unique experience in providing integrated comprehensive health care for the Medicaid population. HIP was created almost 50 years ago as a not-for-profit organization with a mission to provide quality, affordable health care to diverse populations. Today, our system serves nearly 1.2 million members throughout the New York metropolitan area, New Jersey and parts of Florida. We serve 88,000 Medicaid members in New York, 7,700 in New Jersey, and, in addition, serve other employer groups, city, State and Federal Government employees, small business, Medicare, the employed uninsured and uninsured children.

HIP is the largest and most experienced provider of managed care to Medicaid recipients in New York State. We have served Medicaid recipients since the inception of the Medicaid program in 1966. We were the first prepaid health plan in New York State and one of the first in the country to enroll Medicaid recipients. We entered our first Medicaid contract in New Jersey in 1976.

We've written a white paper based on our long-term experience in the Medicaid program. It outlines some of the conclusions and recommendations on essential elements for a successful Medicaid HMO operation, and I'd like that this document be included in the record along with our statement.

HIP has found ways to meet the special needs of our Medicaid members while providing their health care services in the same medical centers and with the same providers as all of our members. In view of the special needs of this population, HIP assigns a Medicaid program officer, most of whom are college graduates and bi-

lingual, to each new Medicaid member. These patient advocates encourage members to use preventive services, such as routine examinations, screening and prenatal care. They assist the member in obtaining appointments, arranging transportation, help the members to understand how to use our system, which is usually very different from what they've been accustomed to, and meeting any other needs that the member may have.

We have found that the programs such as the Medicaid program officer are vital to serving Medicaid members in an HMO setting. It's generally accepted that there is limited use of preventive services in the Medicaid population at large and that there is inadequate care at the beginning of an illness and higher costs later on. In an effort to change this, HIP has developed a number of programs designed to encourage Medicaid beneficiaries to use preventive care services, including well baby, good healthy and retention programs.

The well baby program is in its third year and is designed to give pregnant women incentives to obtain prenatal care. Under the well baby program, when a HIP Medicaid member becomes pregnant, the Medicaid program officer schedules that beneficiary for the necessary monthly prenatal checkups. If the woman attends all the appointments, she is given one free child care item, which can be chosen from a catalogue. The available merchandise includes things like strollers, playpens, carseats, highchairs.

The good health program is in its fourth year and encourages new Medicaid members to schedule a baseline physical examination by offering health-related gifts. The gifts can include fitness classes at the local YMCA and various household items.

The retention program is in its second year and offers a gift to members who have attended all of their appointments after being in HIP for over a year. We encourage the use of mental health programs and in an effort to ensure that our members receive the care they need, they can be referred for psychological help either through their primary care physician or by self-referral.

Our experience shows that HMO's can be successful in providing quality care to the Medicaid population. Because we link each member with a primary care physician, we can provide Medicaid beneficiaries with better care and ensure that they receive coordinated health services.

HIP's recommendations to Congress and to the State is that they consider Medicaid reforms as follows. Health plans serving Medicaid programs should have to meet quality assurance requirements in order to participate in the program. All health plans and providers participating in Medicaid programs should ensure availability and accessibility of services to beneficiaries in the program as a condition of licensure.

All organizations participating in Medicaid managed care should meet solvency requirements that ensure that they have the financial ability to provide the care that they have promised. And Medicaid benefits should remain comprehensive and should include outpatient services, preventive care, inpatient care and emergency services. Payments to Medicaid managed care organizations should be actuarially sound and should reflect the utilization and costs of the population.

The States that we operate in already have this experience, the experience to establish these kinds of requirements. HIP's experience as a provider enables us to demonstrate that innovative programs can be installed that will provide good care to Medicaid recipients.

I thank you for this opportunity to testify.

[The prepared statement and attachment of Jesse Jampol follow:]

PREPARED STATEMENT OF JESSE JAMPOL, M.D., MEDICAL CONSULTANT, HEALTH INSURANCE PLAN OF GREATER NEW YORK

Mr. Chairman, thank you for holding today's hearing. My name is Dr. Jesse Jampol and I am a medical consultant and the retired Medical Director of the Health Insurance Plan of Greater New York, a not-for-profit, prepaid group practice model health maintenance organization operating in New York, with affiliated HMOs in New Jersey, and Florida (HIP Health Plan of New Jersey and HIP Health Plan of Florida). In my capacity as medical director, one of my responsibilities was oversight of HIP's Medicaid program. Furthermore, I was a practicing physician in the HIP system for over 32 years.

I am pleased to present testimony today that outlines HIP's unique experience providing integrated, comprehensive health care to the Medicaid population. HIP also appreciates this opportunity to address some of the important issues raised by the proposal to change the Medicaid program from an entitlement into a block grant to the states.

BACKGROUND

First, I would like to provide the subcommittee with a brief history of the HIP system. HIP was created by Mayor Fiorella LaGuardia during a health care crisis in New York City nearly 50 years ago, as a not-for profit organization with a mission to provide quality, affordable health care to diverse populations.

From its beginning, HIP has offered health care coverage through a community-rating system. This rating system treats everyone as part of the same community—young, old, healthy, sick. It allows varied groups to pay the same price for a wide range of benefits based on the anticipated cost of care for everyone. HIP still views community rating as the best way to spread risk while assuring access to health care for all people.

Today, the HIP system serves nearly 1.2 million members throughout the New York City metropolitan area, New Jersey, and Florida. HIP members are employees of groups as diverse as Fortune 500 companies, federal, state and city governments, middle size and small businesses and we also enroll individuals lacking group coverage. Others receive benefits through the Medicare and Medicaid programs, and some enroll directly in a special plan for uninsured individuals.

In New York and New Jersey, HIP's prepaid group practice system relies on affiliations with groups of physicians devoted on a full-time basis to providing health care for HIP members. Affiliated physicians practice in medical centers with colleagues from virtually every specialty. HIP-New York contracts with six independent medical groups for the services of 630 primary care physicians and 295 specialists. HIP members have access to over 800 consultant specialists on a referral basis. Affiliated physicians care for patients in HIP-owned or leased medical centers. HIP also contracts for care with a number of community hospitals, teaching hospitals, and academic medical centers including New York Hospital, Monetfiore Medical Center, Albert Einstein Medical School's Jack Weiler Hospital, and Beth Israel Medical Center.

We have found our prepaid group model system to be highly effective for a variety of reasons. The emphasis on preventive care helps providers detect illness at its initial stages, making early intervention possible and helping to avoid more costly care for advanced illness. Since the physicians devote themselves on a full time basis to the medical groups, they are free to order any diagnostic tests and clinical services which they believe are appropriate for their patients. The medical groups provide 24 hour, 7 day a week coverage for their patients and they carefully select and retain other physicians as part of their medical group.

In Florida, HIP contracts with 670 primary care and 2100 speciality physicians who provide services in their offices, i.e; the IPA model. In the 8 years since we entered the state, growth has been rapid. HIP Health Plan of Florida now covers 54,000 patients and last year we expanded from Miami-Dade to the Tampa area.

HIP AND THE MEDICAID POPULATION

HIP is the largest and most experienced provider of managed care to Medicaid recipients in New York State. HIP has served Medicaid recipients since the inception of the Medicaid program in 1966 and was the first prepaid health plan in New York State and one of the first in the country to enroll Medicaid recipients. We have written a White Paper based on our long term experience in the Medicaid program. Pages 16 through 20 of the White Paper outline our conclusions and recommendations on essential elements for a successful Medicaid HMO operation. I would like to ask that this document be included in the record along with our official statement.

New York State has currently a voluntary Medicaid HMO program with over 600,000 enrollees of which HIP Medicaid enrollment represents 88,000. We are very pleased that other New York HMOs have joined us in serving Medicaid patients.

Medicaid recipients and special populations present special challenges and responsibilities to a health plan which I describe in this statement. Despite the challenges of serving the Medicaid population, HIP has been effective in providing medical care to low- income populations because of our emphasis on prevention and intervention along with vigorous outreach efforts to educate our members to make maximum use of our services consistent with their health care needs.

HIP insists on a one class system of health care that does not differentiate among groups or individuals based on their ability to pay or by the source of payment we receive for their care. HIP members who are covered by Medicaid have access to all the facilities, doctors, and services as commercial members, a policy which we think all HMOs should employ.

OUTREACH AND ADVOCACY

Success in providing care to Medicaid recipients requires changing some patterns of utilization that many Medicaid recipients have developed. There is general agreement that Medicaid recipients, due to the lack of another alternative, are accustomed to fragmented and episodic care, frequently using emergency rooms for basic medical services. Many Medicaid beneficiaries will also use a variety of delivery sites for care including community health clinics, outpatient departments in public hospitals, shelters for the homeless, and disease specific treatment clinics. HIP has instituted a number of creative programs to help ensure that Medicaid recipients receive the care they need. Perhaps the most innovative policy is our Medicaid Program Officer, who serves as an advocate for HIP Medicaid patients.

Medicaid Program Officers, most all of whom are college graduates and bi-lingual, are located in HIP health centers and help orient and educate new Medicaid members, inform them about services, resolve problems, assist in scheduling appointments, and help select their primary care physicians. They serve as an ombudsman for Medicaid beneficiaries. Medicaid Program Officers encourage Medicaid members to make use of preventive health services including routine examinations, screening, prenatal care, and other health services. They are constantly reaching out to Medicaid beneficiaries in many ways including contacting the beneficiary if they miss a doctor's appointment and ensuring that children get immunized. Through these efforts, Medicaid Program Officers develop personal relationships with many Medicaid recipients which allow them to better assist the members.

INNOVATIVE PROGRAMS

It is an accepted fact that there is limited use of preventive care among the Medicaid population which results in inadequate care at the beginning of an illness and higher costs later on. In an effort to change this, HIP has a number of programs designed to encourage Medicaid beneficiaries to use preventive care including the Well Baby, Good Health, and Retention programs.

The Well Baby program is in its third year and is part of our larger prenatal monitoring program. It is designed to give pregnant women incentives to obtain prenatal care. Under the Well Baby program, once an HIP Medicaid member becomes pregnant, the Medicaid Program Officer schedules that beneficiary for monthly pre-natal check ups. The Well Baby program encourages pregnant women to obtain prenatal care by providing free child-care items such as a stroller, play pen, or highchair to women who keep all of their prenatal appointments. HIP also has an educational program designed to teach first time parents how to take care of their child both during pregnancy and after they take their child home.

Another program HIP has developed in an effort to encourage Medicaid beneficiaries to seek treatment is the Good Health Incentive Program, now in its 4th year. This initiative encourages new Medicaid members to schedule a baseline phys-

ical examination by offering a health related gift. In addition to encouraging Medicaid members to avail themselves of HIP's preventive health care services, these items help members meet their health care needs and those of their children. We believe that immunizations are another important part of ensuring that the Medicaid population remains healthy and offer them to all our members. Medicaid Program Officers track and follow-up all Medicaid children between the ages of 0 and 2 to ensure all necessary periodic services and vaccinations have been obtained. Last spring, HIP implemented a program which offered free immunizations to 10,000 preschool children, including people who did not have coverage through HIP.

Another incentive program HIP has developed to ensure that Medicaid beneficiaries get preventive health care services is our Retention Program, now in its second year. Under this initiative, we review the Medicaid member's files and if they have attended all of their appointments, they are eligible for a gift such as an exercise package at a local YMCA, a food processor, a toaster.

As part of our Medicaid program, HIP offers mental health services. HIP encourages the use of mental health programs and in an effort to ensure that our members receive the care they need, members can be referred for psychological help either through their primary care physician or by self referral. Many times people in need of mental health services are uncomfortable with the idea of going to their primary care physician and asking for a referral. HIP has found that by allowing self referral for an initial assessment, members are more willing to avail themselves of the mental health care they need.

RECOMMENDATIONS

HIP's experience shows that HMOs can be successful at providing quality care to the Medicaid population. In fact, in many cases HMOs can provide Medicaid beneficiaries with better care by linking them with a primary care physician and ensuring that they receive coordinated health care services. Additionally, enrolling beneficiaries in HMOs helps save money for the Medicaid program. HIP receives a payment of $149.02 per month for each Medicaid recipient compared with a cost of $166.91 per month for a fee-for-service beneficiary, a savings of $17.89 per month per beneficiary. Since HIP serves approximately 88,000 Medicaid beneficiaries, HIP saves the state $1.54 million per month in Medicaid costs. Due to these savings, many states have been moving to enroll most, if not all, of their AFDC population into Medicaid HMOs.

Congress is now considering transforming the Medicaid program from an entitlement, which it has been since its inception, to a block grant to states in an effort to save $181 billion out of the Medicaid program by the 2002. Our experience in the Medicaid program cause us to be concerned about such a radical change. It is our observation that problems occur in the Medicaid program when: 1) states do not develop and vigorously enforce health plan standards for HMOs serving the Medicaid population; 2) states seek to expand managed care capacity too quickly before essential data, quality assessment and monitoring capacity are in place.

HIP supports the idea of giving states more flexibility to move its populations into managed care and we have been working with both House and Senate offices to help achieve this goal. However, HIP is concerned about proposals for Medicaid block grants which have absolutely no federal standards. We would be the first to admit that dealing with the Health Care Financing Administration can be difficult. However, HIP still believes that consistent national oversight of health plans in the Medicaid program is needed to ensure the integrity of the program while still allowing states essential flexibility.

HIP believes that under any Medicaid reform proposal health plans should meet national standards for quality assurance systems, solvency, access, data reporting, and physician credentialing before they are allowed to enroll Medicaid beneficiaries. It is our opinion that Medicaid beneficiaries should receive the same consumer protections as patients enrolled through employer groups.

Quality—Plans serving the Medicaid population should have to meet quality standards in order to participate in the program. One measure of quality could be accreditation of a plan by an external independent body where a determination is made that the Medicaid standards are at least as stringent as those for employer groups. Additionally, quality assurance, access and patient satisfaction measures should be applied to all Medicaid providers and plans including fee-for-service and HMOs. They should be carefully designed to provide a set of key quality indicators of special significance to Medicaid programs and the populations they serve. Some quality assurance and data reporting measures must be different than those for employer groups because they must take into consideration the special population needs and the rapid change in eligibility status.

Access—All health plans and providers participating in the Medicaid program should ensure availability and accessibility of services to beneficiaries in the program as a condition of licensure. HIP is proud of its record of having health centers in neighborhoods with large numbers of Medicaid beneficiaries and we work hard to ensure our facilities are conveniently located for all our members. Additionally, HIP Health Plan of New Jersey recently entered into an agreement with the Henry J. Austin Community Health Center of Trenton, a federally qualified health center (FQHC), in an effort to expand our provider base for both the Medicaid and commercial population.

Solvency—All organizations participating in Medicaid managed care should meet solvency standards that ensure they will have the financial ability to provide the care they have promised. Health plans serving Medicaid should demonstrate their ability to meet the same solvency standards applicable to existing, licensed organizations. Strong financial, quality assurance, and fiscal solvency requirements will go a long way toward ensuring that stable and high quality health plans participate in the Medicaid program.

Benefits—Medicaid benefits should remain comprehensive and should include outpatient services, preventive care, inpatient care, and emergency services. Additionally, efforts should be made to coordinate health plan benefits with state social and transportation services in order to maximize services to the Medicaid recipient.

Payments—Medicaid payments to HMOs should be actuarially sound, independently evaluated and should reflect the true utilization and costs of the population. In recent years, some states have placed more and more Medicaid recipients into HMOs and then have reduced reimbursement rates in an effort to help balance their budgets. It is essential that Medicaid rates be set in a manner that reflects the costs of serving this population.

CONCLUSION

HIP's experience as a provider of comprehensive services to Medicaid recipients has been a positive one for HIP, its physicians and the members its serves. Through innovative initiatives such as Medicaid Program Officers, the Well Baby Program, Good Health Initiative Program, and the Retention Program, HIP has been able to reach out to this population and encourage them to obtain primary and preventive care. We are proud of our almost 30 years of service in this program and look forward to serving this population in the future. However, as Congress considers moving to a Medicaid Block Grant, HIP believes that in order to ensure that Medicaid continues to serve its mission, minimum federal standards for health plans and states must be established.

Mr. Chairman, thank you for this opportunity to testify. I will be pleased to answer any questions from the committee.

HEALTH INSURANCE PLAN OF GREATER NEW YORK

PROVISION OF COMPREHENSIVE HEALTH CARE SERVICES TO MEDICAID RECIPIENTS

Introduction

The New York State Legislature, in one of its most landmark decisions, adopted the Medicaid Managed Care Act of 1991. This Act requires shifting of half of the current 2.5 million Medicaid recipients to managed care by July 1996.[1] When fully implemented it promises to improve the quality of care offered to Medicaid recipients while simultaneously resulting in a significant reduction in costs. This dual purpose poses major programmatic and financial challenges to the public officials who must administer the program as well as to the providers who will deliver the care. However, this ambitious time table for expansion has left state and county regulators and managed care providers with limited time to plan and implement these goals.

An important advantage in this effort is the experience that HMO's and other private sector health care providers have had in serving Medicaid recipients. The largest and most experienced provider of Managed Care to Medicaid recipients in New York State is the Health Insurance Plan of Greater New York (HIP), which has served Medicaid recipients since the inception of the Medicaid Program in 1966.

HIP was the first prepaid health plan in New York State and one of the first in the country to enroll Medicaid recipients. In New York City, membership in HIP was made available to Medicaid beneficiaries as early as 1967. With a current enrollment of 71,000 members, HIP's Medicaid membership in New York City con-

[1] New York State Department of Social Services, Social Statistics, April 1994.

stitutes 34% of the total New York City Managed Care enrollment. HIP's voluntarily enrolled total Medicaid membership now exceeds 77,000.

Beginning in the late 1980's, HIP increased its efforts to enroll New York City Medicaid recipients. Within the past five years it has entered into additional contracts to enroll Medicaid recipients in Suffolk, Westchester and Nassau Counties. HIP also participates in the Southwest Brooklyn Mandatory Medicaid Managed Care Demonstration Program and the HIP-Beth Israel Methadone Maintenance Program.

HIP's experience and success in providing comprehensive managed care to voluntarily enrolled Medicaid recipients are positive proof that high quality care can be provided to this population. The legislatively mandated increase in the enrollment of Medicaid recipients into managed care is being achieved through planning, setting realistic expansion goals and addressing the special needs of the Medicaid population.

The purpose of this paper is to provide information about:

(1) The Medicaid Program; (2) Health Insurance Plan of Greater New York; (3) HIP's experience as a Medicaid Provider; and (4) The implications for New York State's Medicaid Managed Care initiative.

1. The Medicaid Program

New York State enacted Medicaid shortly after the enactment of Federal legislation and has conducted a Medicaid Program ever since.[2] The New York State Medicaid Program is unique in two aspects.

Firstly, the range of benefits provided to Medicaid recipients is extremely broad, which is demonstrated by the fact that in fiscal year (FY) 1991 the Medicaid payment per beneficiary was $5.577 against a national average of $2.752.[3] Secondly, unlike other states the local governments bear a substantial share of Medicaid costs. At present, New York City pays 23% of the cost of its Medicaid program, while New York State pays 26% and the balance 51% is the Federal Government contribution. More than 2.5 million persons are enrolled in Medicaid statewide, with 1,606,834 of them residing in New York City, 68,305 in Westchester County, 56,407 in Nassau County and 84,086 in Suffolk County.[4]

The Federal Medicaid legislation enacted in 1965 required the creation of a comprehensive program of health care services for low income persons; a substantial portion of the cost of which would be borne by the Federal Government and the rest by the states.[5] The Federal contribution to each state is based in part on a state's willingness to finance covered medical services and a matching formula. In FY 1992, the Federal and state spending on Medicaid was estimated at $119 billion,[6] by far one of the most expensive Federally supported social welfare programs, next only to Social Security and Medicare spending. Within the limitations of the Federal requirements, the states determine the scope of their respective Medicaid programs and are principally responsible for administering them. Every state has enacted legislation that conforms to the Federal Medicaid law and despite Federal regulation of the program, state programs differ significantly in eligibility criterion and benefits.

1.1 *Problems in the Medicaid Program:*

Despite the generous benefits provided by the New York Medicaid fee-for-service program and large sums of public money devoted to it, public officials and other key commentators have repeatedly observed many deficiencies in the health care services provided to Medicaid recipients and that better care could be made available at reduced cost. The severe fiscal problems of government at all levels have brought these concerns to the fore. Among the problems that have been cited frequently are the following:

1.1.1 *Lack of Access to Primary Care:*

Primary care should be the central component of any health care delivery system. Primary care physicians are the family doctors who see patients for routine ailments, physical examinations, and preventive care. Because their patients see them regularly, primary care physicians know their patients, identify and treat health problems at an early stage before they become more serious, and decide when a patient needs to obtain specialized care from another source.

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[2] New York Social Services Law, Sections 363 *et seq.*

[3] Congressional Research Service, *Medicaid Source Book: Background Data and Analysis,* January 1993, p. 120.

[4] New York State Department of Social Services, Social Statistics, April 1994.

[5] Social Security Act, Title XIX, 42 USCS 1396 *et seq.*, as added July 30, 1965. P.L. 93-233.

[6] Congressional Research Service, *Medicaid Source Book: Background Data and Analysis,* January 1993, p. vii.

A major problem for the Medicaid program has been a severe shortage of primary care physicians to serve Medicaid recipients who seek health care on a fee-for-service basis.[7] New York State Medicaid reimburses physician office visits at rates ranging from $7 to $19.50 per primary care visit, a rate schedule that is among the lowest in the Nation and that discourages many physicians who practice in New York from accepting Medicaid patients.[8] Without access to the normal sources of primary care, many Medicaid recipients resort to hospital emergency rooms and outpatient departments or to storefront medical offices that primarily serve Medicaid patients on an episodic basis.

1.1.2 *Fragmented Care:*

A problem with these substitutes for primary care is that they are often geared to missions other than that of providing continuity of primary care services: a patient sees a physician once for a specific complaint and may never see the same physician again. Arrangements for follow-up of patients are, in some cases, ineffective. Moreover, because the physician is not always familiar with the patient's medical history, he or she will lack information that would be helpful in diagnosis and treatment. Even though the technical competence with which hospital emergency rooms and outpatient clinics provide care may be very high, the lack of continuity of the patient/physician relationship and the difficulty of providing follow up care are among the reasons that the overall care provided is, in many cases, deficient.[9]

1.1.3 *Lack of Preventive Care:*

A striking result of the lack of access to care of Medicaid patients is the limited use that Medicaid patients make of preventive health care services. A 1990 study showed that in some zip codes in upper Manhattan the percentages of mothers receiving inadequate prenatal care was in the range of 35% to 45%.[10] Other services that have proven to be effective in preventing or limiting the severity of illnesses, such as screening and treatment for pediatric bronchitis and asthma, adult bronchitis, pneumonia, malignancy of female reproductive organs, diabetes, ear Infections, and hypertension, are not utilized as frequently by persons in neighborhoods with high Medicaid enrollment as they are by other population groups.[11]

1.1.4 *High Utilization and High Costs:*

Among the significant effects resulting from the way that Medicaid recipients receive health care are the high levels of utilization of many types of health care services. In New York State, Medicaid recipients used 2,600 hospital days per thousand people against 760 hospital days for non-Medicaid patients. Medicaid patients have 15 ambulatory care visits per year compared to the national average of 5.3 visits. It is also believed that Home Relief[12] single adults are by far the highest utilizers of medical services. The statistics attribute 4,440 hospital days per thousand and an average of 30 ambulatory care visits per year to this population.[13] While some of the additional use of medical care is attributable to the social environment in which Medicaid patients live and to their greater vulnerability to illness than other

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[7] Christel Brellochs, Anjean B. Carter, Barbara Caress, and Amy Goldman, Community Service Society of New York, *Building Primary Health Care in New York City's Low-Income Communities,* 1990, pp. 1, 21-28; New York State Department of Social Services, *Third Annual Report to the Legislature on the Implementation of the New York State Managed Care Demonstration Program,* Feb. 1991, p. 1; New York city Human Resources Administration, Family Support Administration, Office of Health Services, *Managed Care Demonstration Project Implementation Plan,* volume 1, September 1990, pp. 1-3, 7-8.

[8] New York City Human Resources Administration, Office of Health Services, *Managed Care Demonstration Project Implementation Plan,* volume I, September 1990, p. 1; New York County Medical Society and the Manhattan Central Medical Society (undated), *Primecare Inc., A Medicaid Partial Capitation Managed Care Program,* p. 2; Health Systems Agency of New York City, February 23, 1991, *Primary and Preventive Care Task Force Preliminary Report, pp. 7-8.*

[9] New York City Human Resources Administration, Family Support Administration, Office of Health Services, *Managed Care Demonstration Project Implementation Program,* volume I, Sept. 1990, p. 2; Christel Brellochs, Anjean B. Carter, Barbara Caress, and Amy Goldman, Community Service Society of New York, *Building Primary Health Care in New York City's Low Income Communities,* 1990, pp. 19, 20, 25-30; The Mayor's Management Advisory Task Force, *Draft Report on Health Care,* April 1, 1991, pp. 13-14.

[10] Health Systems Agency of New York City, *Assessment of Maternal and Child Health Services in Upper Manhattan,* Feb. 1990, p. 66.

[11] Health Systems Agency of New York City, *Analysis of Primary and Preventive Care Needs: Central Harlem, Southwest Bronx, Bedford Stuyvesant/Crown Heights,* July 24, 1989, pp. 1-5; Christel Brellochs, Anjean B. Carter, Barbara Caress, and Amy Goldman, Community Service Society of New York, *Building Primary Health Care in New York City's Low Income Communities,* 1990, pp. 17, 18.

[12] A childless couple or single adult between 21 and 64 who is not disabled, blind or pregnant is eligible for Medicaid if also fully eligible for Public Assistance.

[13] Ronda Kotelchuck, "Medicaid Managed Care: A Mixed Review," *Health/PAC Bulletin,* Fall 1992, p. 5.

populations, the manner in which care is provided to Medicaid patients is also a contributing factor. Lacking access to appropriate primary care, Medicaid patients often report large numbers of visits without receiving the coordinated and continuous care that they need. They often receive inadequate treatment at the earlier stages of their illnesses, become sicker, and are more likely than the average patient to require hospitalization.[14]

The heavy reliance of many Medicaid recipients on hospitals for all types of medical care together with the high levels of utilization makes the care that they receive very costly. These factors have resulted in the paradox that although the fee-for-service care that Medicaid recipients receive is often characterized by the deficiencies described above, the amount that is spent on their care is higher than that of other sectors of similar age groups, including those covered by Blue Cross, commercial carriers, and HMO's.[15]

2. Health Insurance Plan of Greater New York (HIP)

HIP's corporate mission has been shaped by three historical commitments. The first is the provision of affordable health care. HIP is a cost-conscious provider. The effectiveness of its cost containment programs has enabled it to keep its premiums affordable without compromising the quality or accessibility of the medial care that it provides, and to maintain the highest standards of medical care. Rigorous criteria for selection of physicians, an internal and external peer review program, advanced medical equipment and technology, an internal quality assurance program for monitoring patient care, and access to leading hospitals and highly qualified specialists are among the factors that contribute to HIP's ability to maintain its high quality of care. Another of HIP's historical commitments is to serve, to the extent feasible, all segments of the diverse population of its service area. HIP's members include persons from all social, economic, and demographic backgrounds. The diversity and inclusiveness of HIP's membership is unusual among providers of health care benefits in the New York metropolitan area, and it has contributed to HIP's success in overcoming the separation that often exists between health care services for Medicaid recipients and health care services for other population groups.

2.1 *Health Services Delivery Systems:*

Health Insurance Plan of Greater New York (HIP) is a non-profit state-certified, group model HMO serving approximately 1.2 million members in the five boroughs of New York City, in Westchester, Nassau, and Suffolk Counties of New York State and through its affiliates in New Jersey and Southeast Florida.

Health care to HIP's New York members is provided through six HIP-affiliated Medical Groups at 58 centers located throughout the New York/New Jersey area. In New Jersey, more than 175,000 HIP members receive medical care through HIP's New Jersey affiliate HIP/Rutgers Health Plan, a non-profit federally-qualified state-certified group model HMO. Care is provided at fifteen strategically-located Medical Centers from Bergen county in northern New Jersey to Gloucester County in the south. HIP's affiliate in southeast Florida, HIP Health Plan of Florida, provides care to over 35,000 residents of Broward, Dade, and Palm Beach Counties through a non-profit, state certified IPA-model HMO. More recently HIP of New York has expanded its service area to include Orange and Rockland Counties of New York State and also diversified its product range by offering network and point of service options to its members.

After selecting a Medical Center, a newly enrolled member chooses a primary care physician (PCP) within that center to provide the member with basic medical care and to coordinate any additional care. The primary care physician coordinates all medical care, with limited exceptions, making referrals for specialty care and staying apprised of the care a member receives. Medical care is coordinated through HIP-affiliated medical groups, hospitals, and laboratory. A member does not need a PCP referral to see a gynecologist, optometrist, nutritionist, or social worker or to seek mental health, alcohol or substance abuse services. HIP members have the option to change physicians or Medical Center at any time.

2.2 *HIP Affiliated Hospitals:*

HIP contracts with 20 hospitals in the New York service area, and approximately 75% of HIP's New York admissions are concentrated at 15 of these hospitals. Mem-

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[14] The Mayor's Management Advisory Task Force, *Draft Report on Health Care,* April 1, 1991, pp. 9-13; Christel Brellochs, Anjean B. Carter, Barbara Caress, and Amy Goldman, Community Service Society of New York, *Building Primary Health Care in New York City's Low Income Communities,* 1990, pp. 34, 36. New York City Human Resources Administration, Family Support Administration, Office of Health Services, *Managed Cared Demonstration Project Implementation Plan,* volume 1, Sept. 1990, pp. 2-3.

[15] The Mayor's Management Advisory Task Force, *Draft Report on Health Care,* April 1, 1990, p. 8.

bers requiring hospital care are referred primarily to one of these hospitals, depending on the patients medical condition and the physician's hospital affiliation. However, HIP has access to nearly all area hospitals as needed.

2.3 *Mental Health Service Delivery System:*

HIP has been a New York State licensed Article 31. 587/588 mental health provider for over 20 years. HIP's Mental Health Centers provide outpatient treatment for mental and nervous disorders as well as alcohol abuse treatment services. Generally, HIP contracts with substance abuse facilities for the treatment of chemical dependency problems.

The majority of outpatient mental health and alcohol services are delivered at seven (7) regional Mental Health Centers located in each of the five boroughs of New York City and in Nassau County.

In the case of primary psychiatric facilities, the staff at these facilities serve at the approval of the Mental Health Service of HIP. Furthermore, clinical programs are developed through joint efforts between HIP and these facilities.

Services for intensive outpatient alcohol services, which include partial hospitalization, day hospital programs, and residential programs are delivered by fully licensed affiliated, network facilities. All services for substance abuse, including dual/multiple substance abuse and treatments, are provided through an extensive preferred provider network of HIP-affiliated programs. A limited number of HIP plan members also have coverage for methadone maintenance which is available through a similar network of HIP-affiliated programs.

2.4 *Pharmacy Services Delivery System:*

HIP's network of pharmacies at which prescriptions written by HIP-affiliated prescribers may be filled consists of twelve (12) corporate pharmacies at HIP Medical Centers and over 1,400 participating pharmacies. Approximately one-third of the participating pharmacies are chain owned, such as Genovese, Pathmark, Rite-Aid, CVS and Walgreen, and the remaining two-thirds are independently owned and operated. HIP encourages utilization of cost effective medications through the use of generic drugs when possible, a mail order drug program for maintenance drugs, and formularies for oral and injectable drugs. Experimental or investigational drugs (i.e., non-FDA approved) are excluded from the formulary.

2.5 *Centralized Laboratory Services (CLS):*

Laboratory work is coordinated by Centralized Laboratory Services, which HIP and its affiliated medical groups sponsor. The use of CLS helps HIP provide comprehensive and cost-effective laboratory services to its members.

3. *HIP Experience as a Medicaid Provider:*

Medicaid Managed Care offers a way of changing provider and beneficiary behavior which is generally believed to have contributed to escalating costs in the fee-for-service system. Managed care undoubtly is also instrumental in improving the coordination and continuity of care. A study conducted by Rand Corporation in Seattle demonstrated that "persons assigned to the HMO used 40% fewer inpatient hospital days and their overall estimated costs were 25% lower than those for persons assigned in the conventional insurance plan."[16]

HIP's Medicaid Managed Care is the largest and most experienced Medicaid Program on the East Coast. Enrolling and serving New York City Medicaid recipients for more than two decades. HIP's role in Medicaid expanded to include Suffolk County in 1988, Westchester County in 1989, and Nassau County in 1991. HIP's Medicaid enrollment in these counties is 2,467, 1,349, and 1,963 respectively. The largest category of HIP's 76,939 Medicaid recipients is comprised of those who receive Aid to Families with Dependent Children ("AFDC") which constitute about 77% of HIP's Medicaid members. The coverage for AFDC is more comprehensive than HIP's HMO coverage for employer accounts. Under HIP's Physician and Ancillary Program only physician and ambulatory services are covered while hospital coverage is paid for through the general Medicaid fee-for-service system. Enrollment in this program consists mainly of Social Security and Home Relief recipients.

HIP's enrollment of Medicaid recipients has increased rapidly in recent years as a result of joint efforts on the part of HIP, the New York State Department of Social Services, the New York City Office of Medicaid Managed Care in the Office of the Deputy Mayor for Health and Human Services, and the Federal Health Care Financing Administration. With the cooperation of government, HIP has tried a number of different marketing strategies that range from direct mail advertising campaigns to health fairs. HIP's experience has shown that the most effective method

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[16] Congressional Research Service, *Source Book: Background Data and Analysis,* Jan. 1993, p. 120. Willard G. Manning, et al. "A Controlled Trial of The Effect of a Prepaid Group Practice on Use of Services". *New England Journal of Medicine,* volume 310, no. 23, June 7, 1984, pp. 1505-1510.

of increasing voluntary enrollment in Managed Care Plans is a program of one-on-one contact at the Income Support Centers, between marketing representatives and Medicaid recipients.

The effectiveness of this method of marketing has caused HIP to rely heavily on this approach, despite the fact that it is highly labor intensive. The number of marketing representatives devoted to the Medicaid program has been increased from three in 1987 to a current level of 21. The result has been a rapid increase in enrollment. During the twelve month period that ended in December 1993, Medicaid enrollment in HIP increased by 33.18% rising from 56,515 to 75,265.

To achieve this growth HIP had to overcome a number of significant barriers. Namely, Medicaid members have initial difficulty adjusting to an HMO environment and have a tendency to continue to use emergency rooms and non-participating providers. Another barrier to growth is the rapid turnover that occurs as a result of individuals losing their Medicaid eligibility either temporarily or permanently. Typically, 62% of HIP's New York City Medicaid disenrollments occur because of "loss" of Medicaid eligibility due to recipients finding employment, income levels exceeding eligibility limits, or because of delays in obtaining recertification of Medicaid eligibility. As a result of this rapid turnover, HIP's marketing staff must recruit approximately 2,400 new enrollees each month in order to keep Medicaid enrollment at its current level. Despite turnover, HIP strives to increase its Medicaid enrollment and enhance the quality of care provided to its beneficiaries. During 1993-1994, HIP projects an increase of 20.59% in our Medicaid enrollment.

3.1 *Special Programs:*

In addition to its ongoing efforts to expand Medicaid enrollment, HIP is participating in special programs to serve Medicaid recipients. This includes participation in a multiple HMO demonstration program for Mandatory Managed Care Enrollment of Medicaid recipients in Southwest Brooklyn and a program to serve methadone patients that is being conducted jointly with the New York State Department of Health and Social Services and Beth Israel Medical Center. HIP also participates in the Child Health Plus program, an integral part of the Governor Cuomo's bill for health care reform. Child Health Plus was initiated to provide primary care coverage to uninsured and underinsured children ages birth through thirteen in families with incomes up to 220 percent of the poverty level. In addition to our 77,000 Medicaid members, over 11,000 children are enrolled in HIP through this program to date.

3.2 *Improving Health Care Patterns and Expectations of Medicaid Recipients*

Success in providing care to Medicaid recipients requires changing the patterns of acute episodic utilization that many Medicaid recipients have developed. Most commentors agree that Medicaid recipients, usually for want of another alternative, are accustomed to the fragmented and episodic style of care described earlier. They are not accustomed to a more comprehensive and methodical approach to health care delivery that includes periodic physicals. If Medicaid recipients are to take full advantage of the services available to them through HIP, they must be assisted to understand how to use the system.

HIP's effort to acquaint Medicaid members with its system of care start at the time of enrollment. All enrollment of Medicaid recipients by HIP is done in person at the Income Maintenance Centers, HIP Medical Centers or at special events such as health fairs. The direct contact with HIP's Medicaid marketing staff creates an opportunity for explaining the services that HIP provides and the manner in which members can use the services. At the time of enrollment, the member selects the HIP center at which he or she is to receive care, and the marketing representative informs the new members, about the Medicaid Program Officer assigned to that center, who can assist them in learning more about the HIP system. The marketing representative provides the new member with written/audiovisual materials in English or Spanish that explain the health care services they are entitled to as well as how to access the services HIP provides.

3.3 *Medicaid Program Officer*

Crucial to appropriately serving Medicaid recipients, the Medicaid Program Officers functions are essential and requisite to the integration of large numbers of Medicaid enrollees into our delivery system. HIP's Medicaid Program Officers provide each new member with an orientation, assist members in selecting their primary care physician and help resolve problems. Medicaid Program Officers also act as patient advocates by assisting Medicaid members to obtain appointments or service. The role Medicaid Program Officers play has contributed significantly to member satisfaction and to the low rate of voluntary turnover of HIP's Medicaid members.

HIP invites all new members to attend a group orientation session explaining how to use HIP's health care services. Such sessions are held regularly, and Medicaid members are reimbursed for the cost of transportation to and from the meeting.

HIP actively encourages its Medicaid members to make use of preventive health care services. Medicaid Program Officers explain to Medicaid recipients the advantages of routine physical examinations, screening, prenatal care, and other preventive health services. HIP Medicaid Program Officers track new members for a period of six months to assure that they seek and receive routine physical examinations and screening as well as any other services they need.

Because of the positive results described above and the growth of HIP's Medicaid enrollment, HIP has increased the number of Medicaid Program Officers. The present number of twenty nine Medicaid Program Officers includes multi-lingual personnel (Spanish, Haitian, French, Chinese, Russian and Italian).

3.4 In addition to these special programs for Medicaid recipients, HIP has a case management program, staffed by registered nurses, that is available to all HIP members with chronic or complicated conditions. For example, all pregnant teenage members are included in the case management program because they are considered to be at risk. The Case Management program assures that services required by these patients are effectively coordinated, that routine prenatal visits are scheduled, and that there is appropriate follow-up on any problems that arise. HIP also maintains social work services at each center which provides members in need with counselling and community referrals.

3.5 HIP's Medicaid program recognizes the special needs of this population and therefore provides additional support not given to commercial accounts through outreach, incentive and education programs, and special orientation programs. These endeavors have been aided by the strong support of Medicaid agencies at the Federal, State, County and City levels. Such support has been essential to the effectiveness of the program.

At the same time, HIP's attention to the special needs of its Medicaid enrollees does not result in the separation of Medicaid members from other HIP members. All patients receive care in the same facilities and from the same doctors. Apart from enhanced programs to meet the needs of this population, Medicaid members are not distinguishable from other categories of members enrolled in HIP. The success that HIP has had in enrolling and providing care to Medicaid patients represents a significant step towards the goal of including Medicaid recipients in the mainstream of medical care that serves non-Medicaid populations.

3.6 *Early and Periodic Screening, Diagnostic, and Treatment (Child Teen Health Plus)*

The Federal EPSDT requirements are monitored for members age 0 - 21 to ensure that the necessary periodic examinations were performed, that the exam included all required components for that age group and that necessary/required services were provided. If an examination is missed or a service component omitted, the patient is contacted by the MPO, advised of the situation and encouraged to schedule an appointment with his/her HIP primary care physician as soon as possible. All statistics are gathered, analyzed and forwarded to the appropriate medical group for additional follow-up.

3.7 *Good Health Incentive Program*

The Good Health Incentive Program is designed specifically for the Comprehensive Health Plan member. The program encourages families to maintain good health and obtain a baseline physical examination as soon as possible by offering as an incentive, a health related gift. In addition to encouraging AFDC Medicaid members to avail themselves of HIP's preventive health care services, these items help members meet their health care needs and those of their children. A preliminary study conducted by HIP indicated that more new Medicaid members have been obtaining physical examinations than previously and that they have been having their examinations sooner than they had prior to the institution of the incentive program.

3.8 *Prenatal Incentive Program*

The purpose of the prenatal incentive program is to engender prenatal regiment compliance to help prevent premature delivery, low birth weight, and other perinatal and medical problems. This program encourages pregnant women to obtain prenatal care by providing free child-care items to women who keep all of their prenatal appointments.

3.9 *Prenatal Monitoring Program*

HIP's philosophy on prenatal treatment is to provide early detection and on-going care for members. This process is initiated at the time of enrollment. HIP identifies the subscribers who require such treatment from test results and findings of baseline physical examinations. These members are then tracked and followed up by MPO's to ensure that they make and keep their prenatal care appointments.

3.10 *Parenting Program*

This is an educational program designed to teach first time parents how to take care of their child during pregnancy and when they take their child home.

3.11 *Comprehensive Health Plan Dental Program*

HIP offers our CHP membership a dental program. HIP established a capitated general dentistry program with a specialty panel for these members. The CHP dental consultants perform site survey and follow-up site visits at least once a year for each dental office. The site survey includes a review of dental facilities, structure and environment, patient records and radiographic tests, compliance with OSHA regulations and infection control, and appointment availability and access. Utilization Reviews are also performed to identify unusual patterns of practice for an individual office compared to the group experience. A patient complaint tracking system enables us to identify areas of concern for subsequent corrective measures.

3.12 *Immunization Program*

At present, the federal government reports that only 40 percent to 60 percent of preschool children get all the recommended immunizations, and in some innercity neighborhoods the number is just 10 percent. Health officials say the low level of immunization is one reason for outbreaks of measles and other diseases in the last few years.[17] HIP believes that immunizations are a vital part of good health care and offers immunizations to all its members. Additionally, MPO's track and follow-up on all Medicaid enrollees between the ages 0 and 2 years to ensure all necessary periodic physicals and vaccinations have been obtained.

Early last year, HIP responded to President Clinton's call for a joint public-private partnership to develop innovative approaches to vaccinating children. HIP implemented a program in the spring which offered free immunizations to 10,000 preschool children, including people who didn't have HIP health coverage.

4. Implications for New York State Medicaid Managed Care

Medicaid enrollment has grown rapidly despite the large turnover due to loss of Medicaid eligibility. Involuntary disenrollment constitutes 62% of total disenrollments every month due to loss of Medicaid eligibility (Table A).

TABLE A—RETENTION RATE

	December 1993 Enrollees	Members with more than 1 year of enrollment
New York City "Comprehensive Health Plan" Members	53,102	41.35%

One reason for the retention rate is that Medicaid recipients who choose HIP are largely satisfied with the services they receive. The HIP sponsored Medicaid member satisfaction survey has also shown high levels of satisfaction with the medical care provided to its members as demonstrated in Table B.

TABLE B—SATISFACTION RATE

Total Number of NYC Respondents	Satisfied with Medical Care Received During Last Visit at HIP		
	Very Satisfied	Satisfied	Total Satisfied
3,989	49%	35%	84%

HIP has had success in providing improved care to the Medicaid population, many of whom reside in the inner cities, where social factors driven by poverty result in poor transportation, poor housing, inadequate schooling, drug abuse and the disturbing results associated with violence, that make the provision of health care services more difficult than for non-Medicaid populations.

In addition to providing Medicaid enrollees with access to quality care, HIP has significantly improved utilization of health care services. As reflected in Table C, the 79.9% reduction in hospital utilization is significant from a financial perspective.

[17] Robert Pear, "Clinton Considers Plan to Vaccinate All U.S. Children", *New York Times, Jan. 31, 1993.*

TABLE C—INPATIENT UTILIZATION

	Days per thousand
HIP Medicaid 1992 (Actual)	535
New York State[18]	2,600

[18] Ronda Kotelchuck. "Medicaid Managed Care: A Mixed Review". ***Health/PAC Bulletin,*** Fall 1992, p. 5.

We also examined whether Medicaid recipients were receiving appropriate levels of service. Table D demonstrates that the HIP utilization rates for its members are in line with the industry norm.

TABLE D—NUMBER OF INPATIENT ADMISSION/DISCHARGE

	Admissions/Discharges
HIP Medicaid 1992	107.3 admissions per thousand
New York State HMO State Wide Norm 1991[19]	91 discharges per thousand

[19] New York State Department of Health, Bureau of Community Health Insurance and Finance Systems, Draft: 1992 Annual Report for Medicaid Managed Care Plans, Chart H.

Table E shows that while utilization for HIP's Medicaid recipients are lower than Medicaid fee-for-service rates, they are commensurate with those for HIP's non-Medicaid/non-Medicare members.

TABLE E—AMBULATORY CARE UTILIZATION RATE CY 1993[20]

	Encounters/member
HIP Medicaid	3.7
HIP (Non-Medicaid/Non-Medicare)	3.4

[20] Excludes services provided at Mental Health Centers, Diagnostic Imagining, Optometry, Physical Therapy, Dental, Podiatry, Nutrition services, and hospital visits.

These differences reflect special needs of the Medicaid population that result from social and environmental factors leading to increased risk of illness. They are also an indication of HIP's willingness and ability to adapt its level of services to meet the special needs of Medicaid recipients.

HIP's emphasis on appropriate utilization has benefited our Medicaid recipients by minimizing the number of days that they must stay in the hospital, by reducing the number of unnecessary laboratory tests they must submit to, and by sparing them the inconvenience of making numerous uncoordinated visits to physicians. Inappropriate or excessive use of services is a poor form of quality care that affects the provision of services of the Medicaid population. HIP's system of health care delivery through a managing PCP is an effective means of addressing such utilization.[21]

4.1 *Financial Savings to Government*

State and City governments have realized considerable savings in Medicaid expenditures due to HIP's enrollment of Medicaid recipients. Savings to the government will continue to increase as HIP's enrollment increases. For contract year ended June 1993, HIP's monthly per capita premium for providing care to Medicaid recipients was $131.77 per month. The cost of fee-for-service Medicaid coverage for a comparable case mix was $200.63 per member per month.[22] The 34.32% reduction in cost on HIP's AFDC and HR New York City enrollment of 46,346, therefore, resulted in an annual savings to New York State for the twelve month period ending June 1993, of approximately $32 million. Approximately $7.4 million of this amount represented direct savings to the New York City government. Further increases in enrollment in HIP will result in a corresponding increase in savings.

Additionally, expenditures for HIP Medicaid coverage are reduced by the use of community rating to determine the premiums that Medicaid pays to HIP. Medicaid recipients, on the average, use more medical services than the average of HIP's non-

[21] New York City Human Resources Administration, Family Support Administration. *Managed Care Demonstration Project Implementation Plan,* Office of Health Services, Sept. 1990, pp. 2-3; The Mayor's Management Advisory Task Force, *Draft Report on Health Care,* April 1, 1991, Chapter 1, p. 7.

[22] Based on New York State Department of Health, Planning Data Sets, HIP Rate Period July 1992 - June 1993.

Medicaid members. This is true even in a managed care setting owing to factors stated earlier in this document that make Medicaid recipients more prone to illness than the general population. The higher rate of utilization by Medicaid recipients is not reflected in the premium paid to HIP for Medicaid coverage. The result is that Medicaid costs are lower than they would be if the premium were based upon the cost of serving only Medicaid patients i.e. experience rated.

4.2 *Conclusions and Recommendations*

HIP has demonstrated how to provide services to the Medicaid population in a manner that can attract a significant enrollment on a voluntary basis.

HIP is an active participant in efforts prompted by legislative action, to expand managed care for Medicaid recipients through a mandatory program.[23] HIP's experience in this program suggests that mandatory enrollment in managed care of a substantial portion of the Medicaid population raises issues that must be addressed. The effectiveness of any health care delivery system depends in large measure upon the active participation and cooperation of those who are receiving the care. There is a casual link between the success of HIP in providing care to Medicaid recipients and the fact that each person enrolled in HIP made a decision to do so. Whether persons assigned to HIP or who are limited to a selection of HMO's that includes HIP would be prepared to learn about HIP's system and to adhere to its methods of operation is not entirely clear. To the extent that Medicaid recipients are not motivated to do so, the switch from fee-for-service to managed care may be less beneficial, in terms of both improved health care and financial savings, than might be anticipated based on HIP's experience to date. Additionally, mandatory enrollment will quicken the pace at which enrollment proceeds. The enrollment of a large number of Medicaid recipients in a short period of time raises issues of medical center capacity and the difficulty in providing necessary orientation, education and outreach services to Medicaid enrollees.

Proposals to emphasize managed care in the Medicaid program offer significant potential for improving health care services, while reducing the high costs of the Medicaid program. At the same time, it is essential that government officials and providers of managed care work together to develop solutions to the potential problems of a massive expansion of managed care in the Medicaid program. HIP and other managed care providers have had a great deal of experience with Medicaid recipients over an extended period of time and have extensive knowledge of what works and what does not work in providing managed health care to the Medicaid population. This experience and the information derived from it should be of substantial value to government officials in carrying out the ambitious expansion program that is contemplated. The following are among the lessons to be drawn from HIP's experience:

4.2.1 *Governmental Coordination*

Medicaid is an extremely complex program, and responsibility for its administration is divided among all three levels of government. Success in providing services to Medicaid recipients is, in large measure, dependent on the ability of Federal, State, and local government officials to work together. HIP has enjoyed a high level of cooperation from government. This has proven that problems can be resolved promptly and definitively. Continuation of this high level of coordination and cooperation is an absolute necessity for success of the program and for expanding Medicaid enrollment.

4.2.2 *The Importance of Choice*

Success in serving Medicaid recipients appears to be linked to the member's decision to choose HIP as the source of their medical care. Medicaid recipients who are involuntarily assigned to a managed care provider may have less incentive to adapt to and use a new system of health care delivery. The provisions in the recent legislation requiring that at least three plans be offered is a step towards assuring some degree of choice of providers, but it is not clear whether that will prove to be sufficient to motivate Medicaid recipients to use managed care systems appropriately.[24] To maximize the success of mandatory managed care programs, such programs must offer Medicaid recipients as wide and varied a choice of plans as possible. Additionally, Medicaid recipients must be given the opportunity to first voluntarily choose a plan prior to being assigned to one. Lastly, they should also be permitted to change plans when appropriate.

4.2.3 *Emphasis on Education and Orientation*

One of the most significant lessons from HIP's experience, is the relationship between the marketing of HMO services to Medicaid recipients and the education of Medicaid recipients to use HIP's system effectively. Any program of mandatory as-

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[23] Chapter 165, Laws of 1991.

[24] New York Social Services Law, Section 364-j(6)(b).

signment of Medicaid recipients to managed care providers should place even greater emphasis on member education and orientation and member satisfaction.

4.2.4 *Recognized Special Needs of Medicaid Recipients and Provide Appropriate Services to Meet Them*

Medicaid recipients have greater health needs than the general population of comparable age groups. HIP has found the administrative case management functions of the Medicaid Program Officers to be invaluable in helping to assure that Medicaid recipients receive the medical and social services they need.

4.2.5 *Realistic Approach to Costs and Program Goals*

The desired benefits of increased use of managed care in the Medicaid program can be attained only if governmental officials continue to view cost containment goals in the context of the overall program objective of providing high quality comprehensive health care. Governmental financial pressures and the need to control Medicaid costs have had a positive effect in correcting many of the problems with fee-for-service Medicaid, but there is a danger that excessive emphasis on the cost saving aspect of these reforms, unrealistic expectations about the amount of such savings, and underestimation of the challenges of the proposed expansion of managed care could impair the success of the managed care initiatives. The understanding that government officials have had of these difficulties has been crucial to the success of HIP in caring for Medicaid recipients. A continuation of this view of Medicaid reform is necessary to permit HIP and other quality providers of Medicaid services to contribute to progress toward cost containment and improved services.

4.2.6 *Community Rating*

As discussed elsewhere, Medicaid recipients are more costly to serve than HIP's non-Medicaid population. At present, the additional cost to HIP on account of the Medicaid program can be accommodated in the community rate because Medicaid recipients constitute a relatively small portion of HIP's total membership and a large portion of HIP's Medicaid population is in the AFDC category. Should there be a significant increase in HIP's Medicaid population or in the proportion of Medicaid members who are in more costly categories, (such as Home Relief), an alternative rate structure, which would soften the cost impact on HIP while still producing significant savings for government, will need to be developed.

4.2.7 *Benefit Carve Outs*

HIP's experience as a provider of comprehensive services to Medicaid recipients has been equally positive for its physicians and the members it serves. The recently promulgated Memorandum of Agreement concerning the provisions of "Special Care Services" by Medicaid Managed Care programs raises some concerns. HIP believes that any benefit carve out from a comprehensive health care package goes against the very fundamentals of the HMO structure. This is particularly true at the present time when the Clinton Health Security Act bill attempts to provide more comprehensive coverage through Health Maintenance Organizations. HIP has willingly accepted all the provisions of the New York State Special Care proposal. However, any further benefit and rate carve outs are not likely to benefit HMO's or Medicaid members. It will only create more administrative demands on HMOs', have financial implications and impact on HMO's ability to meet the proposed enrollment targets.

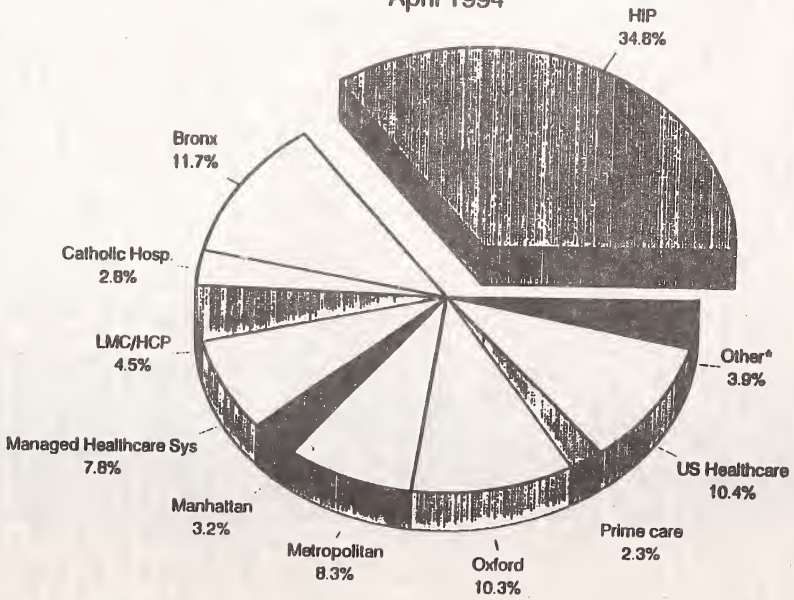
4.2.8 *Limit Administrative Demands for Data*

To the extent that the emphasis on managed care is aimed at providers who serve mainly non-Medicaid patients, it would be helpful for government authorities to reconsider some of the more burdensome duplicative and overlapping data requirements that are imposed on Medicare and Medicaid providers. HIP has extensive internal monitoring procedures, and it is regulated by numerous uncoordinated Government agencies at the Federal, State, County and City levels. While additional data might be appropriate in a situation involving a new HMO or managed-care program or in one whose membership is predominantly Medicaid, such a high level of scrutiny would not appear to be necessary for an established plan like HIP, whose Medicaid membership comprises 8.25% of total enrollment.

HIP's experience indicates that well-managed HMO's are in a position to play a significant role in the effort to improve the quality, accessibility, and cost effectiveness of medical care to Medicaid recipients through the use of managed care. HIP remains committed to an enhanced role in serving Medicaid recipients who become HIP members, whether on a voluntary or mandatory basis.

New York City Managed Care Enrollment Distribution

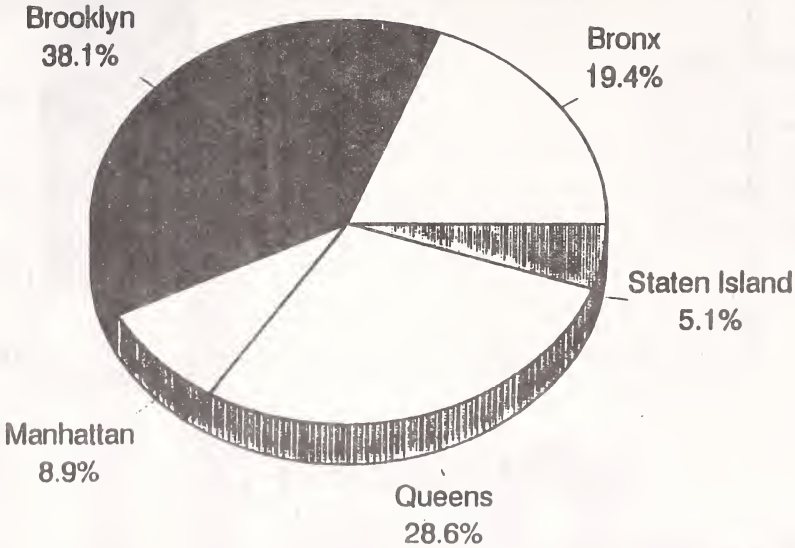
April 1994



*Plans with enrollment share less than 2%

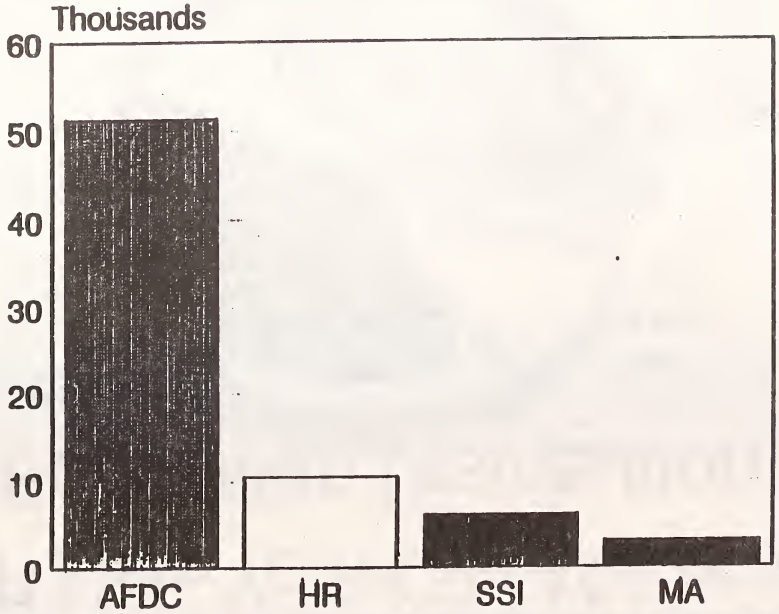
**NYS Department of Social Services, Social Statistics, April 1994

HIP New York City Medicaid Population Distribution



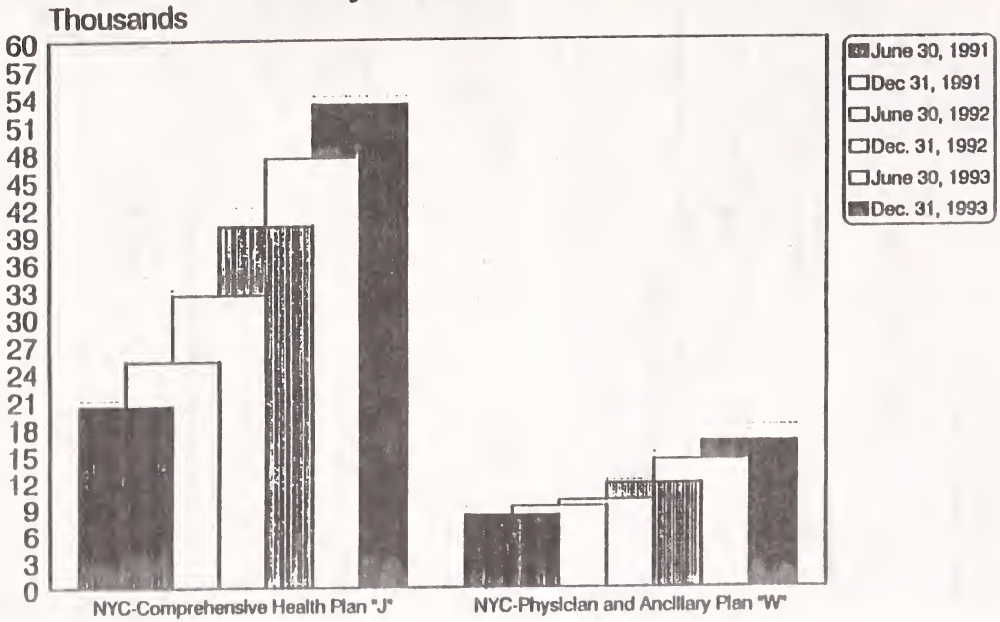
April 1994

HIP NYC Aid Category Distribution



Health Insurance Plan of Greater New York
Comprehensive Health Plan

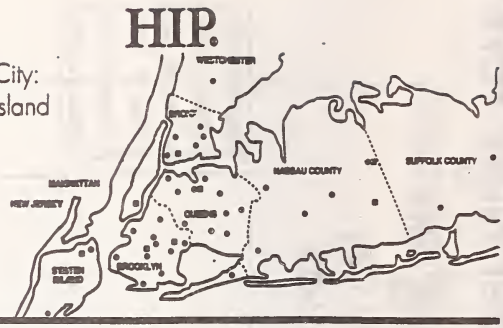
Enrollment Growth for New York City
Bi-Annually June 1991- Dec. 1993



HIP SERVICE AREAS

HIP OF GREATER NEW YORK

The five boroughs of New York City:
The Bronx, Manhattan, Staten Island
Queens, Brooklyn
Westchester County
Nassau County
Suffolk County



HIP/RUTGERS HEALTH PLAN (NEW JERSEY)

Bergen County
Burlington County (except the town of Bass River)
Camden County
Essex County
Gloucester County
Hudson County
Mercer County
Middlesex County
Eastern Passaic County (east of and including Pompton Lakes)
Somerset County
Union County
parts of: Monmouth County
Morris County
Hunterdon County

HIP HEALTH PLAN OF FLORIDA

Broward County
Dade County
Palm Beach County
Pinellas County
Pasco County
Hernando County
Hillsborough County

Mr. BILIRAKIS. Thank you very much, Doctor. Let me just start off with you, if I may, since I made you wait so long. You describe a number of cost saving innovations, not only cost saving, but I would say health effective innovations.

Do you believe that greater flexibility in the administration of the Medicaid program would allow for the development of more health and cost-effective innovations?

Mr. JAMPOL. I am unaware of any particular programs that we wanted to install that we were prevented from installing by the current regulations.

Mr. BILIRAKIS. So you feel there is adequate flexibility, is what you're basically saying. Is that what I should gather from your statement?

Mr. JAMPOL. It's a little hard to answer that very quickly. We who are providing the care, certainly in New York, who have the experience, feel fairly strongly that there are degrees of oversight at the New York City level, at the State level, at the Federal level, which are very duplicative and are often, I think, counter-productive.

On the other hand, we recognize the need for being responsive to the requirements of our members and to the payers. I think a better job could be done that would make it easier for us to function. I'm not prepared at this point to give all the details, but I think it would be best.

Mr. BILIRAKIS. Certainly. Well, these are all, I made the comment earlier, just terrific stories. And the unfortunate thing is that I've heard services being offered, made available that generally do not exist in traditional for-profit, if you will, managed care programs. Isn't that correct?

Maybe I would ask the question. Well, let me ask Ms. Bluestone. For instance, you have talked about the extensive network of primary care and other types of services. You've talked about the community presence and the effectiveness of this network, et cetera, which is so very important. What type of health care access would your Medicaid enrollees have had without your plan's network? Please relate what you're doing for people versus what they would be getting without your presence.

Ms. BLUESTONE. I think it's a good question because often primary care physicians in our program comment that they're out in community health centers, a lot of them are federally qualified health centers, where they're seeing really anybody who comes from the community regardless of their ability to pay. So they've got general Medicaid clients, they've got our clients, they've got folks who are uninsured.

A lot of the clinicians often say they really prefer if the client is in the Bronx Health Plan, because the general Medicaid client who is sitting there, who they will see—I mean, they'll see anybody who comes in the door, right? But the general Medicaid client who they want to refer for, let's say, a cardiology consult or something, they have very limited sources for referral. It's basically going into either a hospital outpatient department, a hospital clinic type arrangement, resident run, or into the city hospital system.

Often the client, the patient is lost to that system. You never hear from them again. You never get back any kind of reports. The

alternative in the managed care system, where you've got a closed network with some expectations and rules about continuity of care, is that they now have the opportunity, if that Medicaid client is in our plan, to refer them to a private practicing cardiologist in our program.

It's a referral that's similar to what any private patient would have. That patient is tended to by the specialist and referred right back to the primary care doc with follow-up information. And what begins to grow is a collegial type of relationship.

I think that's one of the major successes of our program. I'm sure it's true of the others, as well. We've not only improved access for the client, but for a lot of the primary care and other types of providers who have been serving this population and have had very limited sources of care to send them to.

So there's a lot of criticism of HMO's, this notion that you have restricted access. I think with Medicaid clients, the general Medicaid system in itself has been very restrictive. You get a card, but it's a license to search, with very few options available to you. And if anything, Medicaid managed care has actually broadened access when you build broad quality networks.

Mr. BILIRAKIS. Mr. Deutsch wants to ask some questions later. Mr. Murray, for instance, just at random, were you a founder of your health care plan?

Mr. MURRAY. No.

Mr. BILIRAKIS. You were not.

Mr. MURRAY. Well, I was on the State side when it was being founded.

Mr. BILIRAKIS. Why was the Health Care Plan of San Mateo organized? Why was it founded?

Mr. MURRAY. There was great concern that there was limited access for Medi-Cal beneficiaries. They were going out-of-county, going to San Francisco or going to Santa Clara County to get care, that they wanted really to have geographic access.

There was a concern that the local entities wanted to capture the savings that might take place from managing care and plowing it back into health care, because they saw that coming as part of the wave of the future. So they put together a coalition with the hospitals and the physicians and the county government, county health department, working together, saying we want to provide greater access here for our members in San Mateo County and expand the scope.

Mr. BILIRAKIS. There were no for-profit HMO's or managed care facilities that——

Mr. MURRAY. There were 1 or 2 plans that—in fact, one of the major ones, Kaiser, was not a real player and isn't a player today in the program. They chose not to be, whereas in another county they are major players. There was not enough managed care, because it would have been run by the State, not local control. I think that was the thing that made people very interested, that they had seats on the board to help policy determination.

Mr. BILIRAKIS. Thank you. Again, great stories. We appreciate very much your written testimony because we can really go into it in more depth. Mr. Deutsch.

Mr. DEUTSCH. Thank you, Mr. Chairman. I have a couple questions just to kind of flesh out some issues actually as they relate to Florida, as well. I know that HIP has a very active Florida presence, particularly in south Florida, although throughout the State.

Was HIP of Florida one of the Medicaid plans involved in the recent negative reports about Florida health plans?

Mr. JAMPOL. We do have an operation in Florida, but we do not currently have a Medicaid contract in Florida. We have started the process of applying for one, but I don't believe Florida is, at the present moment, certifying any new providers.

Mr. DEUTSCH. And what are the major differences between the Medicaid prepaid plans in Florida and the other HMO's in the State?

Mr. JAMPOL. I believe that what happened in Florida was that in an attempt to enroll large numbers of people into Medicaid HMO's, standards were set up for the Medicaid HMO's which were different from that required of commercial HMO's. I think that's a real recipe for disaster and that what happened could have been predicted. It's, I think, very important that whatever regulations are set up should be comparable in the commercial sector, the Medicaid sector, and any other area that's providing medical care.

Mr. DEUTSCH. Could you be any more specific about what the differences were in terms of the Medicaid HMO's in Florida and your, for instance, HIP? The standards that you have to meet presently since you're not an HMO Medicaid——

Mr. JAMPOL. Well, there were standards having to do with the solvency and for the standards for establishing quality assurance programs that were different for the new Medicaid-only HMO's in Florida as opposed to the commercial HMO's. And because of that, a lot of new players came into the field who were not prepared to provide the standards of care that everybody, I think, has a right to expect. And because of that, the various problems arose.

Mr. DEUTSCH. Now, you have applied for Medicaid certification.

Mr. JAMPOL. Yes.

Mr. DEUTSCH. What will be the differential between your commercial HMO quality of care level of service and the service that Medicaid recipients would be provided for?

Mr. JAMPOL. We are absolutely committed to having absolutely no difference. We expect that our participating physicians may not even know what the source of funding is for any member that they have.

Mr. DEUTSCH. So there would be no distinguishing at all.

Mr. JAMPOL. None whatsoever.

Mr. DEUTSCH. Now, let me, just hypothetically, assuming that block grants are given to the States, Medicaid block grants, and, just in general, Medicaid costs are down. At what level of reimbursement do you think is a threshold level of which quality of care, almost by definition, suffers? I mean, you know what your reimbursement rate is from the State of Florida at the present time. You've done a business plan, I'm sure, to anticipate what their costs are. At what level would you not have a Medicaid HMO?

Mr. JAMPOL. I can't give you the exact numbers for Florida. Our arrangements with our physicians in all of our areas, as a not-for-profit organization, we charge whatever is the minimum amount to

be able to provide all of the services that are included in the contract. I would expect that we would require the same cost to provide care for a Medicaid recipient as it would for a commercial recipient, in addition to which there are certain specific additions that are needed in Medicaid because these are people who are not accustomed to using the system.

Things like Medicaid program officers and so on are an additional expense and I think it's very simple to actuarially figure out what the costs are. In order to provide those kinds of services, I think it would be necessary to do the actuarial studies and be able to provide that level of funding.

Mr. DEUTSCH. Is there anyone else who would want to respond to that? And I think you all understand the basis of my question, which is really what percentage different than the reimbursement level today do we really essentially create a substandard situation. I don't doubt that there will be some entrepreneur out there in the world who will compete basically regardless of what the price is.

But it just stands to reason that at some level, delivery of services is just going to change. To me, that's really the bottom line issue. I mean, there's no question—and we've talked about this and I think the chairman has really done an excellent job at holding really extensive numbers of hearings on these issues. But the bottom line is at what level does quality of care suffer.

Mr. MURRAY. There are a number of factors that go into. One is what are the scope of services that you have to provide, what are you at risk for, and that will affect it. If you have less services that you can provide, then you can do it for less money. Then the question is the number of people that you have that you have to cover.

And if we're revamping dramatically the program and it's only going to grow by a fixed percent regardless of population growth or costs and that's going to be your cost containment, then you have to make decisions and those are pretty much policy decisions that go beyond the health plans and the States would have to decide which optional services would you knock out, who is eligible and who isn't, and then we would have to deal with that and say can we do it for that amount of money, and that's what is very hard to answer.

But clearly we'd have to look at some of the things that we're not mandated to provide now that we do provide would have to be looked at for cutting back.

Ms. BLUESTONE. Mr. Chairman, could I add to that?

Mr. BILIRAKIS. Yes, if you could do it quickly.

Ms. BLUESTONE. Which actually gets back to your earlier question.

Mr. BILIRAKIS. Our trouble is we've got more votes on the floor.

Ms. BLUESTONE. Very quickly. Because it gets back to a question you raised, I think the first question you raised about these wonderful programs and how we can manage to sustain them. I think a real concern is it's not a matter that the State hasn't had the flexibility for us to be able to do these things. There's flexibility there. But as Medicaid budgets, as State budgets get tighter and tighter, decisions about Medicaid managed care are driven more and more by budget decisions, perhaps more so than some of the care decisions.

I think a lot of these beautiful examples you have here today are going to become unaffordable as the rates fall. So it's a matter of, yes, you could do an actuarial analysis based on what Michael was talking about and come up with some bottom lines, but then you also have to ask what about some of these kind of supplemental services that make all the difference in the world, which all of us are basically funding in situations where the budgets have not yet been lowered so severely that you can't afford to do it anymore, I think that's a real concern.

Mr. BILIRAKIS. I am sure that the gentleman would like to have more time and so would I, but we just don't have that luxury. Obviously, budgets are a part of our real world. And that's unfortunate, isn't it? In fact, you all have mentioned the cost-effectiveness of some of your programs and that sort of thing. So you're even concerned with costs.

I really commend you for the great things that you're doing. I just wish that we had programs such as yours all over the country, quite frankly, basically to be able to cover virtually all of the Medicaid beneficiaries. It could be done cheaper, because you don't have the profit motive, and certainly in a much better way, as you have indicated to us.

Again, I thank you for your patience and for the information you have relayed to us here today. This hearing is now adjourned.

[Whereupon, at 3:55 p.m., the subcommittee was recessed, to reconvene at the call of the Chair.]

[The following responses to subcommittee questions were received for the record:]

HIP GOVERNMENT RELATIONS OFFICE,
Washington, DC, August 30, 1995.

HON. MICHAEL BILIRAKIS
Chairman, House Commerce Committee, Subcommittee on Health and Environment, Washington, DC.

DEAR CONGRESSMAN BILIRAKIS: I am writing in response to the questions you sent me from Congressman Edolphus Towns. Attached please find detailed answers to these questions for inclusion in the hearing record.

Thank you for inviting me to testify. Please feel free to contact me if I can be of any further assistance.

Sincerely,

JESSE JAMPOL, M.D.,
Medical Consultant.

RESPONSES TO QUESTIONS OF HON. EDOLPHUS TOWNS

Question 1: Many people have concerns about the ability of managed care to deliver services to Medicaid patients. What special kinds of problems and/or service delivery constraints have you experienced in being able to serve Medicaid patients?

Response: Some concern is warranted because of the significant number of new health plans with no experience in providing health care to Medicaid beneficiaries. Some of these new organizations may have quality assurance, data grievance and consumer education systems which are untested and unproven.

The major problems/constraints are related to encouraging essential behaviors to seek medical care and preventive services early for a population used to receiving acute episodic care. The major challenge is to find ways to have these members accept personal responsibility for their health status which should result in their making maximum use of the primary care services available through an HMO.

HIP addresses this issue through its Medicaid Program Officers who serve as an ombudsman to the Medicaid population. Medicaid Program Officers are located in HIP health centers and help orient and educate new Medicaid members, inform them about services, resolve problems, assist in scheduling appointments, and help select their primary care physicians. HIP has found Medicaid Program Officers to

be very successful in encouraging the Medicaid population to utilize the health care services available to them.

It is important to note that in order to properly serve the Medicaid population, public and private agencies and HMOs need to work together to avoid duplicating scarce health care resources and unnecessary competition. In addition, the public agencies should assist with this issue through education programs which would inform the beneficiaries about the benefits of HMOs, how to use their services and how to best meet their health care needs. This assistance will be essential in the context of all marketing and enrollment becoming a function of the public sector instead of a health plan activity (please see response below).

Question 2: There has been a lot of discussion around eliminating direct marketing to Medicaid patients by New York City and other jurisdictions.

Do you believe that direct marketing can be done in a fashion which is not abusive and which actually helps to educate the Medicaid population about managed care as well as employing people in the local community?

Response: We believe that direct marketing should be allowed for established health plans with a track record of satisfactory marketing and enrollment practices. Those plans employ community residents who are sensitive to the needs and concerns of Medicaid beneficiaries. Even for those plans the regulatory agencies should monitor performance on an ongoing basis. New health plans should participate in marketing efforts which are coordinated by the regulatory agencies until they have established a performance record over a sustained period of time which would permit direct marketing.

MERCY HEALTH PLAN,
Philadelphia, PA, September 8, 1995.

HON. MICHAEL BILIRAKIS,
Chairman, Subcommittee on Health and Environment, House of Representatives, Washington, DC.

DEAR CONGRESSMAN BILIRAKIS: Thank you for contacting Mercy Health Plan on behalf of Congressman Towns who had questions he was unable to pose to us at the Subcommittee's July 26, 1995 hearing, concerning the Transformation of the Medicaid Program.

Attached please find the responses to Congressman Towns' questions. If you or other members of the Subcommittee have questions or would like to know more about Mercy Health Plan, please feel free to contact me. My telephone number is 215-636-6639 and my fax number is (215) 636-6603.

Thank you for contacting Mercy Health Plan.

Sincerely,

SHARMAIN W. MATLOCK-TURNER,
Associate Vice President, Legislative Affairs.

cc: Nancy Sirolli-Hardy
Bret Perkins
Eric Berger
Pamela Greenberg

RESPONSES TO QUESTIONS OF HON. EDOLPHUS TOWNS

Question 1: Many people have concerns about the ability of managed care to deliver services to Medicaid patients. What special kinds of problems and/or service delivery constraints have you experienced in being able to serve Medicaid patients?

Response: Mercy Health Plan (MHP), a Medicaid only managed care plan, has served the Medicaid population in Southeastern Pennsylvania for over twelve years. We have experienced service delivery constraints, however, we view as our responsibility to develop systems to help our members go over, around or through the barriers that restrain their access to quality health care. Many of these barriers in the fee-for-serve system are insurmountable by Medicaid members. There isn't one number to call to find a provider, to access transportation, or to find a translator. Seldom are fee-for-service Medicaid members called repeatedly and visited, urging them to access prenatal care or to immunize their children. Medicaid managed care does this and more.

I have listed below examples of barriers or constraints for Medicaid members and Mercy Health Plan's response to the barriers.

Inability to access providers—One of the most important aspects of our managed care plan is, our members are able to visit with and talk to their primary care physician, dentist and other providers of care when the member needs health care serv-

ices. MHP's has contracted with over 1,000 primary care physicians, 4,000 specialists and 60 hospitals to ensure choice and convenience. Our primary care providers must be available 24 hours a day, 7 days a week. Members also receive around the clock assistance with medical and social problems from our member services department and/or case management department.

Lack of transportation services—Lack of adequate transportation is a serious barrier for our members. MHP assists members in accessing transportation services. However, the problem is not always money. Members may want to know directions or what bus to take to a provider. This information is provided by our 24 hours a day, 7 days a week member services department. Our member service department and our case management and special services areas can make arrangements for public, private and emergency transportation services.

Inability to communicate with providers of care—MHP's member services department has bilingual staff support and access to translation services for languages not spoken at MHP. This service not only helps MHP members communicate with MHP staff but just as important, it allows a provider to communicate with a member. A MHP provider calls our provider services department and he/she can access a translator to communicate important diagnoses and treatment information to his/her patient while the member is in his/her office or is on the telephone.

Lack of prenatal care—MHP determined more than five years ago that we needed to develop a special initiative to assist our expectant mothers and our newborn members. Almost one quarter of our newborns were detained in the hospital for an average of 15 days. With 20 nurses, social workers and support staff who strive to identify every pregnant MHP member as early as possible, MHP's Wee Care Program has reduced the number of detained babies from 24% of all births to 17% in 1994. The average length of stay for those detained went from 15 days to 11.3 days. Wee Care staff work with pregnant members to find suitable housing if needed, drug and alcohol services, prenatal and parenting classes, help with explaining doctor's orders, reimbursement for children and assist with emergency needs. This assistance allows our physicians to focus on the medical condition of our pregnant members.

Incomplete Immunizations—Many Medicaid members cycle on and off Medicaid as their eligibility changes. They may be in fee for service, a managed care plan or have no insurance at all. Often it is difficult for members to remember which shots their children have received and when they were given. MHP recognized the need for a central database in our service area to keep permanent records of immunizations given by private and public providers. MHP made a financial contribution to the City of Philadelphia to assist in developing a central database.

Non-medical social and environmental concerns—Many of MHP's members face social and environmental problems that increase their risk of poor health outcomes. MHP assists members on an individual basis, through our member services and case management staff. MHP staff help members gain access to housing, assist with utility problems and help members locate food and clothing for family members. MHP's staff works with our members to identify community resources and in some instances give direct aid. We also work to strengthen community groups and organizations in our service area to enable them to continue to develop the community supports that can help our members.

Question 2: There has been a lot of discussion around eliminating direct marketing to Medicaid patients by New York City and other jurisdictions. Do you believe that direct marketing can be done in a fashion which is not abusive and which actually helps to educate the Medicaid population about managed care as well as employing people in the local community?

Response: Mercy Health Plan (MHP) and the managed care plans in Southeastern Pennsylvania market directly to Medicaid eligible clients. We market at the county assistance offices on a rotating basis with the other plans. We market at the check cashing centers, community offices and community events. We believe direct marketing is important. Our marketing representatives are the most knowledgeable about and can give the most complete information about the benefits Mercy Health Plan has to offer. MHP believes the Pennsylvania Department of Public Welfare plays a valuable role in this process by providing all Medicaid enrollees with general information about managed care, the benefits of managed care and what is important to consider when choosing a managed care plan.

Helping potential members make informed choices about joining a health plan can be a difficult process. Abuses can occur. This is why Mercy Health Plan adopted Group Health Association of America (GHAA) Guidelines for Ethical Marketing. MHP not only adopted the guidelines but initiated the adoption of the guidelines

by the Pennsylvania Department of Public Welfare. These guidelines are now a part of all Medicaid managed care plan contracts in Pennsylvania.

All Mercy Health Plan marketing representatives are certified by the Pennsylvania Department of Insurance as Health and Accident licensed agents.

All Mercy Health Plan marketing representatives are personally trained in ethical marketing practices by the Senior Vice President of Marketing and Sales. This responsibility is not delegated to other staff. All representatives take an oath and sign a document indicating they understand the principles of ethical marketing and will adhere to these principles. However, marketing representatives are not trained once. Managers review ethical guidelines with marketing representatives on a quarterly basis.

Mercy Health Plan managers monitor marketing activities in the field. During employee reviews, licensure and adherence to ethical standards are reviewed with each marketing representative.

The Pennsylvania Department of Welfare must approve all member materials Medicaid managed care plans use including marketing materials and nominal fee "giveaways". The Department also monitors the activities of marketing representatives in the field and contacts a plan if activities do not meet the guidelines established by the Department.

All of the Medicaid managed care plans in southeastern Pennsylvania meet on a quarterly basis to discuss marketing policies and procedures. This peer review is an excellent vehicle to discuss and solve marketing practice issues.

Mercy Health Plan's marketing representatives are community residents. Several are former welfare recipients, many of whom are active members in their communities. Marketing representative positions pay a livable wage. The average salary of a Mercy Health Plan marketing representative is $28,000 a year plus commission.

THE BRONX HEALTH PLAN,
Bronx, NY, August 29, 1995.

HON. MICHAEL BILIRAKIS,
Chairman, Subcommittee on Health and Environment, House of Representatives, Washington, DC.

DEAR CONGRESSMAN BILIRAKIS: I am writing in response to your letter dated August 14, 1995, regarding the Subcommittee on Health and Environment's hearing on the Transformation of the Medicaid Program. My responses to the questions you pose in your letter are as follows:

Introduction

Under the fee-for-service system, health care delivery to Medicaid recipients has been fragmented and episodic. And, because of the paucity of good quality primary care in impoverished communities, all too often, Medicaid recipients have had to turn to expensive hospital emergency rooms and Medicaid "mills" for their health care needs.

In contrast, here at The Bronx Health Plan, our providers all of which are Article 28, community-based primary care groups, including six Federal Section 330 community health centers—have been able to improve the quality of care provided to Medicaid recipients who enroll in our plan. These improvements result from a) the ability to offer each of our members a relationship with a primary care provider who is *proactive* in serving their health care needs, b) the ability to have access to a superb specialty care network not otherwise available to general Medicaid recipients, c) the availability of extensive TBHP Member Services assistance to help in arranging and coordinating our members' varied service needs, and d) participation in TBHP's utilization and quality management programs.

With the advent of managed care programs such as TBHP, for the first time, Medicaid recipients have access to primary care doctors who know them and can follow their care, better assuring that health problems are identified and addressed at an early stage. And, because of its emphasis on primary and preventive care, managed care has been able to address critical health issues confronted by impoverished communities in a way that was simply not possible under the fee-for-service system. It is against this backdrop, which has often been forgotten in recent discussions, that managed care must be judged.

Challenges We Face in Serving Medicaid Recipients

Question 1: Many people have concerns about the ability of managed care to deliver services to Medicaid patients. What special kinds of problems and/or service delivery constraints have you experienced in being able to serve Medicaid patients?

Response: We do not contend that managed care, in any form, is a complete solution to the health care needs of our indigent citizens. However much we all wish to "mainstream" the provision of health care to Medicaid recipients, the problems associated with the life circumstances of those living in poverty dictate that the mere overlay of the commercial model, without substantial modification, will not work for this population.

Environmental issues that Medicaid recipients and providers face present formidable challenges to managed care programs in assuring effective delivery of health care to their Medicaid-insured members. Medicaid recipients must confront the effects of violence, including domestic violence, and drugs, the prevalence of HIV/AIDS among certain segments of this population, the high incidence of teenage pregnancy, and a general sense among many that they are unable to affect or control the circumstances in which they live. And providers must cope with an almost overwhelming need for their services, working on a supply versus demand curve that almost guarantees their inability to meet the expectations of the people they serve or to perform well against performance measures normally applied in the commercial environment. With the vagaries of their funding sources, they must conduct their business without the certainty of predictable funding for staff acquisition, development, and retention, site development and maintenance, and similar capital intensive activities that are recognized as standard operating procedure in most businesses.

Beyond these issues, to assure that managed care works for both the provider and the plan member, Medicaid recipients must be reoriented in how they obtain their medical care. For example, the importance of making, and keeping, appointments with their doctors is unfamiliar for those who have had to rely on emergency rooms or walk-in Medicaid "mills" for their health care. In addition, targeted, culturally sensitive health education and outreach are necessary to foster Medicaid recipients' ability to seek treatment for health problems at the earliest opportunity—all of which is complicated, in an urban setting, by the circumstances in which many Medicaid recipients live. Fully 40% of our members are without telephones. Without targeted outreach, these members would be lost to us.

The instability of Medicaid eligibility is, in addition, a significant constraint on the ability of TBHP to provide its members who receive Medicaid with continuous, coordinated care. At TBHP, we are proud of our low disenrollment rate. In June, while the total disenrollment rate was 3.7%, our voluntary disenrollment rate was a mere 1% of the total. Thus, fully 73% of our members who were disenrolled in June (and the statistics are similar from month-to-month) did not choose to do so—they became ineligible for Medicaid. For these members, when Medicaid eligibility is lost, the physician-patient relationship is broken, and with it the benefits that managed care can provide.

The relationship between governmental agencies and their business partners in establishing and maintaining good managed care programs is also critical to the success of Medicaid managed care. When governmental regulatory authorities are slow to complete their tasks (e.g., when rate scales are not approved in a timely manner) or strike an attitude that is adversarial, rather than one that fosters mutual respect and problem-solving, the public is not well served. Indeed, unsound governmental policies and practices can and have run the real risk of preventing all of us from reaching our common goals—good quality, cost-effective health care for all of our citizens.

The sudden and unpredictable changes in direction that government policy has taken in the last two to three years have severely hampered business's ability to plan for the future, including critically needed planning for and investment in expansion of much-needed primary care capacity. Indeed, in inner cities and remote rural areas, the lack of sufficient primary care capacity threatens to bring the expansion of managed care availability to Medicaid recipients to a halt.

An example of the damaging effect of a sudden change in governmental policy is the recently instituted ban on all direct plan enrollments in the City of New York. While, as discussed more fully in our response to Question 2, there is a need for governmental oversight of plan marketing, the sudden, blanket ban on all plans in New York City has had several negative side effects. For example, several commercial banks have shown considerable interest in working with TBHP to finance new site construction. Citing our healthy balance sheet and anticipated growth, these banks regarded TBHP as a good risk, one to which they could offer favorable loan terms. Since the announcement of the enrollment ban, however, these banks are now questioning the viability of our business plans, and regarding TBHP as a higher risk venture partner than they previously thought.

If managed care plans continue to be subject to these kinds of harsh, unpredictable changes in governmental policy direction that prevent their ability to plan and

invest—and to find suitable investment partners—areas with among the highest concentrations of Medicaid recipients in the country will continue to be left to the increasingly costly vagaries of the fee-for-service system.

Challenges We Face Related to Marketing and Enrollment

Question 2: There has been a lot of discussion around eliminating direct marketing to Medicaid patients by New York City and other jurisdictions. Do you believe that direct marketing can be done in a fashion which is not abusive and which actually helps to educate the Medicaid population about managed care as well as employing people in the local community?

Response: TBHP condemns fraudulent and abusive marketing tactics. Irresponsible behavior on the part of some plans damages all managed care plans, as well as governmental managed care initiatives. We do not believe, however, that the evidence of such grievous behavior by some warrants a ban on direct marketing and/or enrollment by all.

While we agree that direct enrollment by managed care plans can lead to fraud, abuse, and misleading information by some if the system is not effectively monitored and regulated, the choice of states such as New York to eliminate all direct plan enrollments and move to an enrollment "broker" is not a panacea. Many, if not all, of the kinds of infractions that led to the ban of direct enrollment in New York City, for example, could have been avoided by effective regulation of both market entry and ongoing operations of the offending plans. (In New York City, plenty of evidence from early on indicated that some of the newer, more aggressive, managed care plans were likely to—and did—create problems.)

Plan marketing and enrollment activities, if done responsibly, provide an engine for local economies as well as an effective vehicle for forging strong ties between managed care plans and the communities they serve. A very high proportion of our staff are Bronx and upper Manhattan residents (our current service area). We make a strong effort to recruit marketing and member services staff, both of which are labor-intensive functions, from the communities we serve, including entry level positions that provide administrative support for these functions. If these functions are reduced or eliminated, the economic benefits are lost as well.

Together, government and managed care plans need to identify ways to ensure informed Medicaid recipient choice while optimizing enrollment growth. We suggest that the solution lies in combining the strengths of a broker system with that of direct marketing and enrollment by managed care plans under carefully regulated and monitored conditions.

Features of this alternative include the following.

—Governmental distribution, via mail and direct hand-out, of generic materials about Medicaid managed care, as well as brief descriptions of individual health plans. In this way, all Medicaid recipients will have the opportunity to receive basic, generic managed care information. As New York City has done in the past, government can also mount a generic managed care marketing campaign to promote the program with positive messages about the benefits of enrollment.

—Education/enrollment workers should be available at appropriate government facilities, such as Income Support Centers, to educate Medicaid recipients about managed care and their health plan options, and to assist Medicaid recipients in completing enrollment applications.

—Only managed care plans that have demonstrated acceptable, appropriate marketing and enrollment practices (as measured by factors such as staff training programs, supervisor/field staff ratios, voluntary disenrollment rates, State "look back" interviews, Medicaid recipient and provider complaints, member satisfaction, etc.) should be permitted to conduct marketing and direct enrollment activities.

—Government should staff an audit unit that conducts quality control reviews of enrollment applications submitted by individual managed care plans before those applications are processed. The audits should be done on a sample basis, with the option to do a 100% review if there is reason to suspect the quality of a plan's enrollment activities. Such an audit function will have a sentinel effect on health plans, conveying a clear message that care should be taken with every enrollment application, since any one of them may be subject to audit. The audit function will also give the government flexibility to target its staff efforts, redeploying resources to concentrate on areas of most concern at any given time.

—To make this system work, government must establish standards, and enforce negative sanctions (e.g., suspension or termination of the permit to

conduct direct enrollment), on those managed care plans that demonstrate non-compliance or problematic practices.

TBHP and many other managed care plans have, for years, conducted marketing and sales activities in a responsible manner. To TBHP, direct marketing, including enrollment, is not just a means to sign people up; it is, instead, an opportunity to begin a service relationship with our new member. We have always regarded the enrollment interview as critical to establishing a meaningful, positive relationship between our health plan and our Medicaid recipients. The enrollment interview has been key to our success in bringing new Medicaid recipients into our provider network and in converting current provider registrants to managed care coverage. It is clearly in our interests to have "quality" enrollments; i.e., members who are well-informed and who make a positive choice to join our plan.

Managed care provides an opportunity, for the first time, to provide high quality, coordinated care that is cost effective to our most indigent citizens—a goal that is not possible under the Medicaid fee-for-service system. We look forward to our continuing partnership with government to make this goal a reality.

We hope that our responses to the questions you have posed are helpful and appreciate the opportunity to share our views with you.

Sincerely,

MAURA BLUESTONE,
President and CEO.

TRANSFORMATION OF THE MEDICAID PROGRAM

TUESDAY, AUGUST 1, 1995

HOUSE OF REPRESENTATIVES,
COMMITTEE ON COMMERCE,
SUBCOMMITTEE ON HEALTH AND ENVIRONMENT,
Washington, DC.

The subcommittee met, pursuant to notice, at 10:11 a.m. in room 2123 Rayburn House Office Building, Hon. Michael Bilirakis (chairman) presiding.

Members present: Representatives Bilirakis, Hastert, Stearns, Klug, Franks, Greenwood, Burr, Bilbray, Whitfield, Ganske, Norwood, Coburn, Waxman, Brown, Deutsch, Pallone and Dingell (ex officio).

Staff present: Howard Cohen, majority counsel, Mary M. McGrane, majority counsel, Melody J. Harned, majority counsel, Eric Berger, majority professional staff, and Bridget Taylor, minority professional staff.

Mr. BILIRAKIS. The hearing will come to order, please.

Mostly for the benefit of those of you who haven't spent much time with us up here and don't quite understand what's going on, this is a relatively large subcommittee but, as you see, I am the only one here for the time being; the ranking member is not able to make it. It is a terribly busy time of the year for us and, between other hearings and some people are on the floor and things of that nature, that's basically the way of things, so people will be coming in and out, I will be going in and out and Mr. Waxman will be in and out. Staff will be in and out so, please, forgive us in advance. It is not a lack of respect for the witnesses as much as it is just the nature of the beast up here. I thought I would explain that.

We probably will have a number of interruptions. When the bells ring, that generally means a vote on the floor of the House. We ordinarily have a number of interruptions and this is a very long hearing, five panels, so we are bound to have many interruptions.

Well, today's hearing provides us with the opportunity to continue this committee's in-depth analysis of the Medicaid program and what we can do to fix it. In the five hearings we have held on this issue to date, we have heard testimony about Medicaid's explosive cost and administrative complexity. We have heard compelling testimony about the impact Medicaid's many problems have had on beneficiaries and the States in which they live and we have been presented with a picture of what Medicaid can become, a flexible

program providing better service delivery, administrative efficiency and beneficiary satisfaction.

Today's hearing addresses yet another important element of our inquiry, how advocacy groups and other organized interests view the Medicaid program and its proposed reform. We all have very personal and compelling views about Medicaid. No one involved in this reform effort sees our objective as dismantling a program that is essential to millions of low-income Americans. In fact, we are motivated in this effort by the conviction that what we are doing will strengthen and preserve the Medicaid program for years to come, and that's our goal. That is the goal of everybody up here, regardless of how we may disagree with the way to go about it.

However, debate is an essential element of any healthy democracy, and I am sure today will prove this adage to be true. I welcome all who have been able to join us here today, and I am grateful that you will share your views with us as we seek to improve a program that is important to us all.

[The prepared statements of Hon. Cliff Stearns, Hon. Charlie Norwood and Hon. Tom A. Coburn follow:]

PREPARED STATEMENT OF HON. CLIFF STEARNS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF FLORIDA

Mr. Chairman, my remarks today will be rather brief because I believe we are all anxious to hear from our distinguished panel of witnesses. It is important that we hear from providers because they know firsthand the ins and outs of the program and the needs of the people this program serves.

Medicaid was established to provide a safety net for poor women and children. However, a greater portion of care delivered under this program goes to the needs of the elderly and the disabled.

I would like to give a special welcome to Ms. Beatrice Braun from Spring Hill, Florida. It was very good of you to take the time to appear before us today. I noted, in particular, your comments about the qualified Medicare.

Beneficiaries (QMB's). I do not think it is the intent of this committee to take away the ability of low-income persons to access the Medicare program. We know the importance of ensuring that all individuals, especially the indigent will continue to have the ability to access health care.

I also want to comment on a portion of your testimony Ms. Checkett. One of your suggestions concerned States that will have to deal with unforseeable events such as natural disasters, higher-than-expected growth in the number of Medicaid eligibles, or sudden economic downturns. I found this to be quite relevant since Florida is susceptible to all three.

Your idea about the establishment of a specific State option contingency fund that would be separate from other Federal Medicaid allocations is one that I think we should explore. States like Florida and California share many of the same problems and such a contingency fund would certainly alleviate the additional strain such high growth States must endure.

As we all know, 10 States have applied for and received section 1115 waivers, but I'm not sure this is the answer. Nevertheless, 13 additional States are still awaiting HCFA's approval of their pending applications. The popularity of these demonstration projects may be due in large part to the fact that this is the only form of relief available to Governors seeking greater flexibility for their program.

Again, thank you for holding this hearing Chairman Bilirakis. I'm sure we all find it most beneficial.

PREPARED STATEMENT OF HON. CHARLIE NORWOOD, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF GEORGIA

Mr. Chairman, thank you for calling today's hearing. Under your leadership we certainly are exploring the breadth, height and depth of Medicare and Medicaid with these many and frequent hearings.

After reviewing some of the advance testimony from our witnesses, I'd like to make a few comments.

I am encouraged by some who have recognized the need for turning many of the functions of Medicaid over to the States through block grants. Goals such as "granting States greater flexibility," as have been advanced by the National Association of Public Hospitals are encouraging. Also the observation that we not "overexpand and overpromise" relative to managed care within the system, I believe is on target.

It appears the Administration has gotten half of our message. The Vice President's top aide on health care, stated, in criticism of block grants for Medicaid, that the States would do an awful job with Medicaid just as the Federal Government has done. At least they admit that Medicaid is not working at the Federal level.

But the typical big government solution is offered: don't trust the States and the people closest to the poor and infirm; keep trusting big bureaucratic government in Washington with its dismal track record.

It is discouraging that the Administration prefers to criticize from the sidelines rather than work on sensible solutions.

Mr. Chairman, thank you again for bringing some sanity to this process. I look forward to today's testimony and I yield back the balance of my time.

PREPARED STATEMENT OF HON. TOM A. COBURN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF OKLAHOMA

Thank you Mr. Chairman. Medicaid spending has dramatically increased over the past several years. In fact, Medicaid costs have been growing at nearly twenty percent a year. This rate is more than four times the growth of medical spending as a whole, and at least six times the general rate of inflation.

I have discussed the future of Medicaid with present and past HCFA administrators. I have also discussed it with the Governor of my own State of Oklahoma. Like the other Governors who testified before this Committee recently, he believes that the States should be given the opportunity to take control of this program.

I agree that the States can handle this program better than the Federal Government has. I am confident that solutions to the problems of Medicaid can best be developed at the State level. After all, the States can reform Medicaid to fit the needs and concerns of each of their own unique populations. Unfortunately, the costly, monolithic Medicaid system in place now is unable to do so.

I hope that today's witnesses will provide us with insight into the problems of administering Medicaid and possibly offer some solutions. I look forward to hearing their testimony.

Mr. BILIRAKIS. The first of the five panels consists of Ms. Donna Checkett, director of Missouri Division of Medical Services. She is the Chair of the National Association of State Medicaid Directors representing the American Public Welfare Association. And Ms. Diane Rowland, senior vice president with Henry J. Kaiser Family Foundation here in Washington, D.C.

I welcome you both and as per usual your written testimony is made a part of the record and I will ask you to try to keep your remarks as close to the 5 minutes allowable as possible.

Please proceed, Ms. Checkett.

STATEMENTS OF DONNA CHECKETT, ON BEHALF OF AMERICAN PUBLIC WELFARE ASSOCIATION; AND DIANE ROWLAND, ON BEHALF OF HENRY J. KAISER FAMILY FOUNDATION

Ms. CHECKETT. Good morning, Mr. Chairman. I appreciate this opportunity to testify before you today about the critical issue of Medicaid restructuring. I am Donna Checkett representing the American Public Welfare Association and I am also the director of the Medicaid program in Missouri.

We have a series of recommendations to make to you as you set about the important task of restructuring Medicaid and looking at ways to curb Federal spending in Medicaid. I would like to state first of all that APWA has not endorsed nor opposed block grants

nor capped entitlements. We have not taken a position on either of those. Our policy recommendations focus on the structural components of the Medicaid program.

I know you have heard from a number of individuals, including Governors, over the past weeks about the need for State flexibility and we have a series of recommendations that we believe are critical if States are to achieve much needed flexibility. The first of those would be the repeal of the Boren Amendment. Second, we call for a repeal for cost-based reimbursement for federally qualified health centers. We also call for a modification of the EPSDT program which is a well-intended child health program that has resulted in coverage for Medicaid children that is far in excess of that available to children who receive health coverage under commercial insurance.

We also call for a repeal of existing Federal statutory restrictions on Medicaid managed care. We would specifically like the repeal of 75/25 restrictions, although there are other restrictions in Federal statute as well.

And, finally, if Congress restructures the Medicaid program and does indeed reduce Federal spending by $182 billion over the next 7 years, then we call for a passing on to States for the ability to set eligibility, benefit and payment levels in order for us to meet the impact of that reduced Federal funding.

I know that you have heard a great deal about funding and reallocation among States for base years and we have several proposals regarding that critical issue. First, we recommend that States' allocation be based on expenditures incurred in the fiscal year immediately preceding the enactment of Medicaid reform and that States be guaranteed that funding level for the next 2 years as well as annual increases that would be agreed upon in Federal statute. We believe those annual increases should be higher in the first 2 years as, I believe, are indeed in the conference recommendations.

We then call for the establishment of a bipartisan commission that would advise Congress on adjustments that should be made to this base year funding in the out years of 1998 through 2002. And this commission would look at items such as demographic factors, economic conditions and population growth.

We also call for the establishment of a contingency fund. This fund will allow States financial assistance if they have had to deal with unforeseeable events, such as a natural disaster, sudden economic downturns or higher-than-expected growth in the number of Medicaid eligibles. We do call for this to be a separately funded contingency fund separate from the current funds dedicated for Medicaid spending.

I know you have heard a great deal from Governors about waivers and we do call for the elimination of the current Federal restrictions on waivers. We think that States have many years of experience in operating freedom-of-choice waivers, home and community-based waivers and we should be able to do this as part of our State plan process.

There is a lot of concern about States with section 1115 waivers and we do recommend that States that have these waivers either approved or pending approval at the time of enactment of Medicaid

reform should be able to continue to operate those waivers under the terms of the agreement they negotiated with the Federal Government. If operating this waiver program would result in increased Federal expenditures above that that would be otherwise available, we do feel these Federal funds must come from a separate pool and not from the overall pool now for Medicaid.

An item I would like to specifically address is the interrelationship between Medicare and Medicaid. Both of these programs provide health insurance for the same individuals, low income, elderly, and disabled. Medicaid pays for the premiums and copayments for low-income Medicare beneficiaries.

We are extremely concerned that Medicare savings and the plans to achieve those savings will include increases in premiums that Medicaid agencies would have to pick up as part of our responsibility for paying for low-income dually entitled. This would be an unacceptable cost shift to States.

Another aspect I would like to address is that the two programs, Medicare and Medicaid, are designed to support our most expensive individuals in this system, yet right now they are different funding sources, different authorizing committees in the House, different administration, and it is ironic that there is no way to coordinate the funding and care for the single most expensive group of people in our country and we do believe that States should have the ability to coordinate the care, and that includes the funding for the dually entitled individuals by enrolling them in managed care and again coordinating the funding and care of those individuals.

Mr. BILIRAKIS. Will you please summarize, Ms. Checkett?

Ms. CHECKETT. Yes.

We do believe that transition issues are critical to the States and we ask for the ability to work with you in transitioning. Our State legislatures will have to change laws and regulations, we will need to hold public hearings and we ask that there be no penalties or sanctions while we are implementing the new program.

I thank you very much for your time. A copy of our recommendations in depth is attached and has been submitted for the record. Thank you.

[The prepared statement of Donna Checkett follows:]

PREPARED STATEMENT OF DONNA CHECKETT ON BEHALF OF THE AMERICAN PUBLIC WELFARE ASSOCIATION

Mr. Chairman and members of the committee, I appreciate this opportunity to testify about a restructured Medicaid program and the need for increased state flexibility. I am here to testify on behalf of the American Public Welfare Association (APWA), the non profit bipartisan organization founded in 1930 that represents the 50 cabinet-level state human service departments, and the 56 Medicaid agencies. I am also speaking as Medicaid director for the state of Missouri.

For years, states have provided high-quality, cost-effective services to vulnerable populations including the frail elderly, the disabled, and low-income women and children. There are currently 36 million people enrolled in the Medicaid program. Of these, low-income women and children account for only 27 percent of Medicaid spending even though they represent nearly 75 percent of the beneficiaries. The bulk of our Medicaid dollars are spent for services to the elderly and the disabled, largely because of their need for both acute and long term care.

We recognize and appreciate the need for slowing the growth in federal spending, and we understand that reforming entitlement programs, including Medicaid, is necessary to achieve this goal. In this effort, states have repeatedly sought greater flexibility from federal rules and regulations so that we may use our resources to better serve eligible individuals. Medicaid spending has risen steadily, not only for

the federal government, but also for the states; it now accounts for an average 20 percent of all state spending. As federal mandates have increased, state spending has increased. If federal financial support is to be limited, the need for greater state flexibility in program management takes on greater urgency.

On July 7, 1995, APWA's National Council of State Human Service Administrators adopted a comprehensive set of recommendations for Medicaid reform. The full text of these recommendations is attached for the record. I would like to highlight several recommendations for the Committee this morning: first, the need for enhanced state flexibility, regardless of what mechanism is adopted by Congress to reduce federal spending; second, funding issues, including a new and creative allocation proposal; third, the future of existing waiver programs in a restructured Medicaid program; fourth, the inter-relationship between Medicaid and Medicare; and fifth, the need for an adequate transition period to implement changes. APWA has not recommended whether Medicaid should remain as a federal entitlement or whether it should be converted to a state entitlement block grant, if Congress restructures the current Medicaid program with restricted federal funding.

State Flexibility

It is state officials who administer the Medicaid program. However, each state's ability to *manage* Medicaid is sorely constrained by federal actions. States have been allowed some discretion in determining eligibility, benefits, and payment rates. But over the past decade, Congress has narrowed that discretion by mandating coverage of specific populations, specific benefits that must be offered, and payment rates that must be paid to certain providers as well as special mechanisms for nursing home admissions. These new mandates are contributing to the escalating costs of the Medicaid program and are adding to its complexity. Here is a sample of costly federal mandates and other prescriptive federal rules added by Congress over the past few years.

First, the Boren amendment, while intended to provide states with some freedom in developing institutional reimbursement policy, has evolved through court actions to become a financial nightmare, drastically limiting the states' ability to set reasonable rates for facility services. APWA calls for the repeal of the Boren Amendment.

Second, Congress has mandated that states must pay certain providers, notably those established under the federal programs for Federally Qualified Health Centers and Rural Health Clinics, 100 percent of their costs. This requirement should be repealed as well.

Third, comprehensive health care for children is a national concern, yet the screening of Medicaid eligible children according to pre-determined periodicity schedules established under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program often complicates continuity of care, and results in duplicative and sometimes unnecessary services and costs. APWA calls for a modification of this requirement.

Fourth, states attempting to control Medicaid expenditures have opted to enroll Medicaid eligibles into managed care organizations. However, existing limitations on contracting with managed care plans, such as the requirement that Medicaid and Medicare beneficiaries together may not comprise more than 75 percent of plan enrollment, continue to limit states' ability to effectively manage the care of these individuals. These limitations must be eliminated.

Finally, if Congress restructures the Medicaid program and reduces federal funding by $182 billion over the next seven years, then APWA recommends that the responsibility for setting eligibility, benefit, and payment levels be given to the states.

Funding and Allocation Recommendation

Several witnesses in earlier hearings have discussed their concern that there be an equitable allocation of federal Medicaid dollars among the states. We have a proposal to address the Medicaid allocation issue.

Allocation Formula. APWA recommends that state allocations be based on expenditures incurred during the fiscal year immediately prior to enactment of Medicaid reform, and that the states be guaranteed that funding level as well as annual increases agreed upon in the statute for the following two years. The rates of growth should be higher in the first two years in order to assist states in making the transition to a restructured Medicaid program.

Further, APWA calls for the establishment of a bipartisan commission that will make recommendations to Congress regarding the adjustments that should be made in federal payments from Fiscal Years 1998 through 2002. The commission should consider adjustments based on a variety of factors including economic conditions, benefit levels, eligibility criteria, population growth, and other demographic factors.

Contingency Fund. Some states may find that, even with increased flexibility, they will be unable to avoid drastic cutbacks in their programs. In addition to the costs associated with the transformation of existing state Medicaid programs over the long term, states will have to deal with unforeseeable events such as natural disasters, higher-than-expected growth in the number of Medicaid eligibles, or sudden economic downturns. Funding must reflect the fact that the calculation made for a base year might not include the full annualized cost of program changes or partial-year program costs. To enable states to successfully implement a redesigned Medicaid program, APWA strongly recommends the establishment of a specific state option contingency fund that would be separate from other federal Medicaid allocations.

Waivers

For many years states have been allowed to make changes in their Medicaid programs, beyond what is allowed by federal statute, through waivers obtained by formal applications to the Secretary of the Department of Health and Human Services. These changes have enabled states to implement different service delivery arrangements that provide greater cost containment or service access. Waivers are approved in three major categories: those that limit the choice of service providers; those that enable states to use home and community-based services instead of institutional care and those that permit state demonstrations of new approaches to service delivery. States appreciate the efforts by the Health Care Financing Administration (HCFA) to improve these processes, but the waiver application, approval, and renewal process is still time-consuming and costly. APWA recommends that the federal requirements that necessitate waivers be eliminated.

Ten states—Arizona, Tennessee, Oregon, Hawaii, Rhode Island, Kentucky, Florida, Ohio, Delaware, and Massachusetts—have received federal approval to operate statewide Section 1115 waivers to demonstrate service delivery innovations, especially expanded use of managed care. Vermont expects formal approval later this month. Seven states have applications pending. These states have invested a great deal of effort and resources in these waivers, and have shown good-faith efforts to control costs.

We are concerned about the fate of these waivered programs under any proposed Medicaid changes. APWA recommends that states that have Section 1115 waivers approved (or submitted by July 1, 1995, and subsequently approved) should have the option to continue to operate those waiver programs under the terms of the agreement negotiated with the federal government. If a state chooses to continue its waiver program, and to do so would result in federal expenditures that exceed federal allocations to that state, federal funds for this purpose should come from a separately identified fund, and not be taken from the overall federal dollar pool. Furthermore, if a state chooses to discontinue its waiver program, it should not incur a penalty for failure to achieve budget neutrality requirements during the years that the waiver was in operation.

Inter-relationship of Medicaid and Medicare

Both the Medicare and Medicaid programs provide health insurance for the same individuals: the lower-income elderly or disabled. State Medicaid programs buy Medicare Part B coverage, and pay the co-payments and deductibles for persons receiving Supplemental Security Income (SSI) benefits. In addition, states are required to buy both Part A and Part B Medicare coverage for elderly or disabled persons (called Qualified Medicare Beneficiaries, or QMBS) whose incomes are too high to qualify for SSI benefits, but are below 100% of the federal poverty level. The QMB coverage was mandated by Congress in OBRA 1988, and was to be funded from the money states would save as a result of expansion of *Medicare* coverage of nursing home services and prescription drugs. In 1989 the Medicare expansions were repealed, but the state mandate to provide QMB coverage remained. In fact, the mandate was enlarged to include Specified Low-income Medicare Beneficiaries (SLMBs), whose incomes are between 100 and 120 percent of the poverty level. Today, state expenditures for these two groups alone are projected at nearly $4 billion a year.

The Congressional budget resolution assumes Congress will identify ways to spend $270 billion less for Medicare benefits over the next seven years than is projected under current law. If those reductions are achieved through increasing beneficiary cost-sharing liabilities and raising the Part B premiums, some of the Medicare savings will result in increased Medicaid costs, because Medicaid will pay those premiums and deductibles. This would be an unacceptable cost shift to the states.

The implications of Medicare changes for the Medicaid program, however, go well beyond the issue of premiums costs and co-payments. These two major programs

Medicare and Medicaid—are designed to support our most expensive patients. Medicare funds the hospital and physician care, and Medicaid pays for the nursing home, extended care, and drugs for thousands of the very frail elderly, for example, persons with Alzheimer's disease, cancer patients, stroke victims, and persons with AIDS. Yet the programs operate on two separate tracks, with different funding sources, different administration, and, in this body, even two different authorizing committees. Thus no one entity can manage the care of these individuals.

APWA recommends that, at a minimum, states should have the flexibility to manage the care of dually eligible individuals by enrolling them in managed care and to tap both the Medicare and Medicaid funding streams to pay those costs. In the absence of this flexibility, the federal government should assume full financial and program responsibility for this population.

Transition Period

Any federal change in Medicaid triggers a series of changes that must be made at the state level due to administrative practices or state laws. These changes involve significant challenges for the implementation of any restructuring of Medicaid. The attached chart on "Steps Required to Make a Significant Change in a State Medicaid Program" details the process states must follow to implement changes in Medicaid. While the total amount of time needed from conception of the change to its actual implementation will vary depending upon the magnitude of the revision, even a minor change in reimbursement policy cannot be put into effect by any state overnight.

In consideration of the necessary changes that states must implement, Congress should assist states in making information system and administrative program changes during the transition period. In addition, states will likely be operating multiple systems during the transition period. For this reason, there should be no penalties, sanctions, or other liabilities associated with the implementation of the new system.

Conclusion

Congress is proposing to reduce Medicaid spending by $182 billion over the next seven years. The most important factor to consider when designing a restructuring of Medicaid is that there are people behind all these numbers. Medicaid clients must be considered as well as the states that administer Medicaid programs. Medicaid is not just a state bureaucracy that can be painlessly downsized. Reduced federal funding can translate into fewer services for beneficiaries and fewer individuals receiving benefits. This means fewer low-income pregnant women, children, frail elderly, and disabled individuals receiving the services that they need, fewer services available to those who need them, or it could mean lower payments, and perhaps less willing providers, for persons needing services. Medicaid is the safety net for the poorest and most vulnerable individuals in this country. Any drastic changes that are considered in the Medicaid program should be made with regard to what happens to these individuals. States will try to preserve the Medicaid safety net, but we cannot do it without flexible tools, adequate funding, and an appropriate transition period.

I thank you again for this opportunity to testify and I would be happy to respond to any questions.

Mr. BILIRAKIS. Thank you. Thank you so much.

Ms. Rowland.

STATEMENT OF DIANE ROWLAND

Ms. ROWLAND. Thank you, Mr. Chairman.

I am pleased to be here this morning to talk about the Medicaid program and the important role it plays in financing health and long-term care services for 1 in 8 Americans.

Today, Medicaid's role as a health insurer and safety net for vulnerable Americans is visible throughout our health care system. Medicaid finances care for 1 in 4 American children, pays for over a third of the Nation's births, assists 60 percent of people living in poverty, provides for half of all nursing home care for frail, elderly and disabled Americans and supplements Medicare by maintaining premiums and cost sharing available for 1 in 10 elderly and disabled Medicare beneficiaries.

From a beneficiary perspective, Medicaid is predominantly a program assisting low income families but from the perspective of how Medicaid dollars are spent, Medicaid is a program serving the low-income, aged and disabled population.

Half of Medicaid's beneficiaries are children but they account for only 15 percent of spending. It is the care of the elderly and disabled that make Medicaid a costly program.

The Congress is now considering converting Medicaid from an entitlement to a block grant and capping Federal Medicaid spending to realize savings of $182 billion over the next 7 years. This would amount to an 18 percent reduction in projected Federal support for Medicaid over this period and a 29 percent reduction in the year 2002. The reduction in Federal funds, in combination with the block grant, will severely strain the ability of most States to meet the demands placed on them by a growing poverty population and increasing elderly population and growing numbers of uninsured. With increases in the number of Americans living in poverty, especially American children, and decreases in employer-based insurance coverage, Medicaid has been both a safety net and a safety valve in our health care system. By capping Federal contributions and eliminating the individual entitlement to coverage, a block grant leaves both States and their low-income residents vulnerable in times of economic downturn.

An alternative approach is to retain the existing entitlement nature of the program but provide States with greater flexibility over program eligibility, benefits and provider payments. Federal savings could be accomplished by reducing Federal matching rates, setting limits on the rate of growth per beneficiary to allow for enrollment growth and redistributing and limiting spending for disproportionate share hospital payments. This approach builds on the current framework of Medicaid and preserves its safety net role while providing States with broadened ability to restrain program spending.

There are no simple solutions to reducing the costs of providing care to over 36 million Americans who now depend on Medicaid or the millions more who fall just beyond its reach. There are just hard choices. The changes in this program will affect 1 in 8 Americans. Those who are among the poorest, the oldest, the frailest and most disabled of our population. There is no magic bullet or painless solution. Broadened use of managed care requires time to implement and has limited potential for overall savings unless extended to the elderly and disabled, both groups where there is limited experience with managed care.

Reductions in Federal support will ultimately mean cuts in already low provider payment rates, reduction in benefits, cuts in eligibility or some combination. It will pit poor children against elderly and disabled users of long-term care in dividing up limited funds in State legislatures. Restraining the rising cost of care for the vulnerable populations served by Medicaid without compromising the vital safety net role of the program is a difficult task. But maintaining the safety net for the children, elderly and disabled who count on this program for their care should be the guiding principle in shaping the future of Medicaid.

In implementing solutions to meet the crises of today, it is important not to undo the progress Medicaid has made in providing health care for tens of millions of low-income, elderly and disabled Americans.

Thank you for this opportunity to testify.

[The prepared statement of Diane Rowland follows:]

PREPARED STATEMENT OF DIANE ROWLAND, SC.D., SENIOR VICE PRESIDENT, HENRY J. KAISER FAMILY FOUNDATION AND EXECUTIVE DIRECTOR, KAISER COMMISSION ON THE FUTURE OF MEDICAID

Thank you Mr. Chairman and members of the Committee for this opportunity to provide an overview of the Medicaid program and the role it plays in financing health and long-term care services for low-income Americans. I am Diane Rowland, Senior Vice President of the Henry J. Kaiser Family Foundation and Executive Director of the Kaiser Commission on the Future of Medicaid.

The Kaiser Commission on the Future of Medicaid is a fourteen-member bi-partisan national commission established by the Henry J. Kaiser Family Foundation in 1991 to serve as a Medicaid policy institute and forum for analyzing, debating, and evaluating future directions for health care for poor and vulnerable populations. I am pleased to be here today to share the work of the Commission and discuss Medicaid's role as a safety net for the health and long-term care needs of 36 million low-income Americans.

Medicaid's Role Today

Since its enactment in 1965 as companion legislation to Medicare, Medicaid has been on the front lines in meeting the health needs of our nation's most vulnerable populations. Medicaid has evolved from a program providing financing to states for health coverage of their welfare population to a program that now finances health and long-term care services for one in eight Americans. Over the last 30 years, Medicaid has enabled millions of low-income Americans to gain access to needed health services. It has helped to close the gaps in care between the poor and non-poor, eased financial burdens, and provided a safety net for the most needy Americans. It has been a major force in shaping health and long-term care services for low-income families and aged and disabled Americans.

As the primary source of health financing for the poor, Medicaid has clearly demonstrated the importance of insurance in obtaining access to care. Before Medicaid, access to physician and hospital services for the poor lagged considerably behind that of the non-poor. Since the enactment of Medicaid, steady progress in narrowing these gaps has occurred. The value of Medicaid is underscored by the contrast in outcomes between the poor with Medicaid and the uninsured poor. For most indicators of access to care, the uninsured lag well behind those with Medicaid while those with Medicaid fare comparably to the privately insured.

Today, Medicaid's role as a health insurer and safety net for vulnerable Americans is visible throughout the health care system. Medicaid finances care for one in four American children, pays for one-third of the nation's births, assists 60 percent of people living in poverty, pays for half of all nursing home care for frail elderly and disabled Americans and accounts for 13 percent of all U.S. health care spending. It is the source of insurance for 13 percent of the non-elderly population and supplements Medicare by paying premiums and cost sharing for one in ten elderly and disabled Medicare beneficiaries. Its funding is the major source of federal financial assistance to the states, accounting for 40 percent of all federal grant-in-aid payments to states.

Authorized under Title XIX of the Social Security Act in 1965, Medicaid is a means-tested entitlement program that is jointly financed by the federal and state governments. States elect to participate in Medicaid and federal requirements and state choices determine Medicaid's structure. The federal government matches from 50 to 79 percent of program expenditures, depending on the state's per capita income.

States design and operate the program within federal guidelines that determine the population groups and services for which the federal government will match state expenditures. The federally required eligibility groups and services account for 44 percent of program spending while the remainder consists of coverage of eligibility groups and services offered at the option of each state. Because states make different decisions about whom to cover, what benefits to provide, and what to pay for services, the scope and cost of the program vary widely across states.

In reality, Medicaid is four separate programs, configured and operated somewhat differently in each of the 50 states and the District of Columbia. For 16 million children and 7 million adults in low-income families, Medicaid is a health insurance program with comprehensive benefits and little or no cost-sharing. For nearly 4 million low-income elderly people and 5 million low-income people with disabilities, Medicaid has multiple roles. It is a long-term care program for home- and community-based services and the dominant source of public financing for nursing home care. In addition, Medicaid is a supplementary insurance program to Medicare paying Medicare's premiums and cost-sharing requirements and covering additional services, most notably prescription drugs and long-term care, for low-income Medicare beneficiaries. For low-income disabled adults who do not have Medicare coverage, Medicaid also serves as a health insurance program.

From the perspective of whom is served, Medicaid is predominantly a program assisting low-income families; from the perspective of how Medicaid dollars are spent, however, Medicaid is a program serving primarily the low-income aged and disabled population. As shown in Figure 1, adults and children in low-income families make up nearly three-fourths of beneficiaries, but account for only 27 percent of spending. In contrast, the elderly and disabled account for 27 percent of beneficiaries and the majority (59 percent) of spending because of their intensive use of acute care services and the costliness of long-term care in institutional settings.

Elderly beneficiaries rely on Medicaid mostly for long-term care financing while the disabled beneficiaries are heavy users of both acute and long-term care. Because aged and disabled beneficiaries use more (and more expensive) services, the cost to Medicaid to cover them is substantially higher than is the cost for children and adults in low-income families. As shown in Figure 2, the average per beneficiary Medicaid cost in 1993 was $1,191 per child and $2,067 per non-aged adult compared to $7,956 per disabled beneficiary and $9,293 per elderly beneficiary. With an almost eight-fold difference between the cost of a child and an elderly beneficiary, the cost of any state's Medicaid program is largely determined by the mix of beneficiaries covered by the program.

Medicaid is thus an expensive program because it provides health insurance coverage and long-term care financing for many of the nation's poorest and most disabled individuals. It is a safety net for individuals with the most catastrophic of illnesses—chronic illnesses for children that can leave them disabled for a lifetime, mental illness and retardation that requires intensive care in the community or in an institutional setting, and long-term nursing home care for the aged and disabled. Medicaid's average cost for a pregnant women or child without complex medical needs is often substantially lower than a comparable private health insurance premium whereas the average cost for a severely retarded individual on Medicaid can exceed $50,000 per year, an expense not covered by most private insurance.

In filling these roles, Medicaid has become a major budgetary commitment for both the federal and state governments. In recent years, Medicaid expenditures have escalated rapidly, more than doubling from $51 billion in 1988 to $125 billion in 1993. It is projected that total federal and state spending for Medicaid will exceed $158 billion this year and grow to $308 billion by 2002. The federal share, roughly 56 percent of total expenditures, is projected to grow from $90 billion in 1995 to $177 billion in 2002. Federal expenditures for Medicaid now account for 6 percent of the federal budget while state Medicaid funds account for 13 percent of state spending.

Although historical rates of growth for Medicaid have been more moderate than increases in private health care spending, Medicaid costs rapidly accelerated in the late 1980s with annual rates of increase in excess of 25 percent between 1990 and 1992. The excessive growth rates during this period were attributable to several factors, including a national recession and growth in the number of people eligible for Medicaid, inflation in health care spending, and states' use of statutory loopholes to leverage additional federal dollars.

Spurred by federal requirements to increase coverage of pregnant women and children, state efforts to cover more low-income uninsured, and court-required expansions in coverage of the disabled, enrollment increased from 22 million in 1988 to 32 million in 1993. As shown in Figures 3 and 4, low-income children accounted for the largest share of the growth in Medicaid enrollment, but coverage of additional children with low per capita costs played a relatively minor role in Medicaid's rapid growth during the 1990s.

The major factor contributing to the spike in program spending was that some states generated additional federal dollars from Medicaid by using provider taxes and donations and disproportionate share hospital (DSH) payments as alternative financing strategies to increase the base payments that had to be matched by the federal government. As shown in Figure 5, state efforts to maximize federal Medic-

aid funding had the most pronounced effect. Between 1991 and 1992, over half of the annual increase in Medicaid spending was attributable to rapid growth in federal DSH payments, concentrated in about 15 states. By 1993, DSH payments accounted for 14 percent of total Medicaid spending.

With legislation enacted in 1991 and implemented in 1993 to restrict state use of tax and donation financing strategies and to curb the growth in DSH payments, the annual rate of growth in Medicaid spending has now dropped back to historical levels. The changes in the provider tax provisions and the cap on DSH payments have clearly closed some of the mechanisms used by states to increase federal Medicaid payments. With the new rules in effect, the program grew by 11 percent from 1992 to 1993 and future projections assume an annual growth rate of about 10 percent. Future increases are expected to be driven primarily by inflation and enrollment growth due to increases in the number of people in poverty and expanded coverage of children below poverty.

The Challenges Facing Medicaid

The Medicaid program's current structure as an entitlement for low-income, elderly, and disabled Americans and as an entitlement to states for federal matching funds for individuals and services that fall within federal guidelines provides a safety net for both states and their low-income residents. The matching funds provided by the federal government through Medicaid enable states to respond to changes in the economy that affect the number of poor and uninsured in each state, to accommodate population growth, and to undertake health and long-term care reform at the state level. Individuals are guaranteed coverage if they meet the eligibility requirements.

Medicaid's role in providing acute and long-term care services to our nation's most vulnerable people and its widening safety net responsibilities have brought about notable improvements in coverage of low-income families and assistance to poor elderly and disabled Medicare beneficiaries. But this progress has also resulted in spending growth that is straining both federal and state budgets. The tension in the program comes from the pressure to maintain and expand services to the poor, elderly, and disabled while constraining the cost of the program's safety net role. The challenge is how to meet growing needs with limited resources.

Providing Health Insurance to the Poor and Uninsured

Medicaid is the primary source of financing and coverage for the low-income population and has been a critical force in moderating the growth in America's uninsured population. Without Medicaid, millions of poor children would be uninsured. As shown in Figure 6, 58 percent of all Americans living in poverty and 82 percent of all poverty-level pregnant women and young children are now covered by Medicaid. If the growth in Medicaid over the last five years had not offset the decline in employer-based insurance for working families, an additional nine million Americans would be uninsured today, increasing the percent of non-elderly Americans without insurance from 18 to 22 percent.

Today, 41 million Americans, two-thirds of whom have incomes below 200 percent of the federal poverty level, are uninsured. As a means-tested entitlement program, Medicaid finances care for persons who meet stringent and state-specific income and asset limits and who fall into particular "categories," such as people receiving cash assistance or low-income children and pregnant women. Despite recent extensions of coverage to poor children and pregnant women, millions of uninsured low-income Americans, most notably poor individuals and couples without children, remain beyond the program's reach.

Many states have sought waivers from the federal Medicaid eligibility requirements to gain flexibility to use Medicaid as a building block in their state health care reform efforts. With waivers, federal matching funds can be used to help pay the cost of insuring low-income individuals who are not in Medicaid's traditional coverage categories. As shown in Figure 7, 12 states now have federal waivers of Medicaid law (known as Section 1115 waivers) that allow them to experiment with changes in the scope and structure of their Medicaid programs to cover additional low-income uninsured people and to use managed care to restructure the delivery and financing of services. Thus, waivers provide states with a way to use federal dollars to assist in state efforts to expand coverage.

The pressure to use Medicaid coverage as a way to assist the growing low-income uninsured population is unlikely to abate as employer-based coverage continues to decline. Additional pressure to expand Medicaid coverage is also likely to result from the continuing growth in the numbers of Americans, especially children, living in poverty.

Filling Medicare's Gaps

In recent years, Medicaid has also been pressed to expand the assistance offered to low-income Medicare beneficiaries. Today, nearly 4 million low-income disabled and elderly Medicare beneficiaries rely on Medicaid to pay the premium and cost-sharing obligations under Medicare and provide benefits that Medicare does not cover, most notably prescription drugs and long-term care. In 1995, Medicare's Part B premium is $533.20 per year and cost-sharing requirements are $716 for a hospital stay, a $100 deductible for physician services, and 20 percent cost-sharing for physician and other medical care.

In essence, Medicaid makes Medicare work for the low-income elderly and disabled by reducing their financial barriers to care under Medicare. However, providing this coverage to the dual beneficiaries of Medicare and Medicaid imposes financial obligations on state Medicaid programs. Increases in Medicare's obligations on beneficiaries translates to higher Medicaid costs to finance these payments, but states have no control over the level of Medicare premiums and cost-sharing. Many states argue it should be the responsibility of the federal government, not Medicaid, to pick up the additional cost to low-income beneficiaries when costs to Medicare beneficiaries increase.

In addition to its role in supplementing Medicare, Medicaid is under pressure because it provides the only public source of financing for long-term institutional care for individuals with severe physical and cognitive limitations. Medicaid pays for half of all nursing home care and about 20 percent of long-term home- and community-based care. In the absence of adequate private financing alternatives, setting appropriate limits on Medicaid's availability to help families and individuals with long-term care will continue to be a source of tension in program policy and spending.

The pressure on the Medicaid program to assist the low-income elderly and disabled is likely to intensify in the coming years with the growth in the elderly population, especially the oldest old who are at the greatest risk of needing nursing home care. In addition, if the proposed Medicare spending reductions result in increases in Medicare premiums, deductibles, and cost-sharing, new pressure will be placed on Medicaid to help fill those gaps and protect the poorest Medicare beneficiaries from increased financial burden.

Stretching Dollars Through Managed Care

Many states have turned to managed care as a model to coordinate care and help control costs for the Medicaid population by setting a fixed payment per enrollee and putting the health plan at risk for delivering needed services. By shifting from a fee-for-service based program to managed care, states hope to make coverage costs more predictable and achieve savings to reduce the growth in program spending and stretch coverage dollars further.

Medicaid managed care enrollment has grown steadily in the last decade from 800,000 enrollees in 1983 to 7.8 million in 1994, as shown in Figure 8. Today, 23 percent of Medicaid beneficiaries, predominantly poor children and their parents, are enrolled in managed care. More than half of Medicaid managed care enrollees are in Health Maintenance Organizations (HMOs) or similar organizations that provide a full range of services for a fixed capitation payment per enrollee.

Managed care is not, however, an instant solution to Medicaid's access and cost problems. Managed care works most effectively if the enrolled population is stable and can receive ongoing preventive and primary care, but a program such as Medicaid that determines eligibility on the basis of income has significant eligibility turnover because people lose coverage due to fluctuations in income and employment. As a public program, Medicaid also operates under budget constraints that have often resulted in substandard provider payment rates. In a capitated managed care arrangement where the incentive is to keep utilization low, substandard payment rates could discourage participation by mainstream plans and compromise quality and access.

Moreover, significant savings for the overall Medicaid program cannot be achieved if enrollment managed care focuses only on low-income families. As shown in Figure 9, only 23 percent of overall program spending is related to acute care services for low-income children and adults. Even if managed care is able to achieve the savings of 5 to 15 percent over fee-for-service reported in the literature, these savings on care for low-income families would result in a 1 to 2 percent savings for the overall program.

Achieving significant overall program savings from managed care will be difficult without enrolling the costly disabled and elderly populations into managed care. The disabled account for half of all acute care spending under Medicaid. Almost 60 percent of all Medicaid dollars are spent on services to the elderly and disabled, but the experience with these populations in managed care is limited and the potential

for savings is unknown. Moreover, because much of the spending for aged and disabled beneficiaries is on long-term care, savings on care for this population will require spending less on costly institutional long-term care services, an area in which savings have been particularly difficult to achieve.

The extent to which states will be able to achieve savings from managed care is also highly dependent on the current configuration of their Medicaid programs. States that have a heavier share of their Medicaid dollars in long-term care services will be less able to achieve significant savings than those with a larger share of spending in acute care services, where managed care has its greatest potential for savings. As shown in Figure 10, there is substantial variation across states in the level of spending related to acute versus long-term care services.

Finding a way to maintain or expand coverage with fewer resources has become a challenge for every state. Although managed care has emerged as a strategy to rechannel resources, the potential for savings from this approach should not be overestimated and the need for an adequate infrastructure of managed care plans to achieve these savings should not be overlooked. With budget limitations, the pressure to shift care for the elderly and disabled into capitated plans will intensify, but given the limited experience with managed care for this population, those with severe disabilities and chronic illnesses should not be put at risk.

Choices for Medicaid's Future

As it enters its thirtieth year, Medicaid is at a critical juncture. In its role as a medical safety net, Medicaid currently finances care for more than 36 million of the poorest, sickest, and most disabled Americans at a cost of over $159 billion to federal and state governments. But, the program has been a victim of its own success. While Medicaid was broadening its reach in providing health insurance to the poor and becoming the mainstay of financing for long-term care, increased program spending called into question the ability of the federal and state governments to sustain such growth.

Today, the Congress is proposing to curb federal Medicaid spending to realize savings of $182 billion from projected federal spending between 1996 and 2002. This would amount to an 18 percent reduction in projected federal support for Medicaid over this period and a 29 percent reduction in the year 2002. As shown in Figure 12, the growth limits would have a wedge effect with the largest share of the reductions occurring in the last two years.

To provide the states with the flexibility to redesign their Medicaid programs in response to the federal funding limits, proposals are being discussed that would replace the current entitlement program with a block grant to the states. Instead of guaranteeing insurance coverage, protection for nursing home residents, and federal financing for all individuals who meet Medicaid's eligibility criteria, a block grant would provide states with federal funds and the flexibility to decide how those funds can be used.

Under the proposals being discussed, states would gain discretion over the scope and design of the program, but lose unrestricted federal matching payments because federal payments to the states would be capped. If the distribution of future federal dollars is based on the current allocation of federal dollars to states, the expenditure reductions would be distributed unevenly across states as shown in Figure 13.

In general, high-income states, such as New York and New Jersey, that have historically spent more on Medicaid would receive smaller percentage reductions in federal payments while low-income states, such as Florida and West Virginia, that have historically spent less on Medicaid would have higher percentage reductions. States experiencing increases in their low-income population, such as Florida or Texas, are also disadvantaged by a historically based formula. Adjusting the formula to assist high-growth states would result in deeper reductions for high-expenditure states, such as New York and New Jersey.

The reduction in federal Medicaid spending coupled with the proposed end to the entitlement nature of Medicaid will undoubtedly result in significant changes in the scope of coverage of the poor, elderly, and disabled and the way in which their care is organized and financed. The level of the proposed reduction in federal funds is deep and will severely constrain the ability of most states to meet the demands placed on them by a growing poverty population, an increasing elderly population, and growing numbers of uninsured.

In considering the options for restructuring this program and reducing the level of federal dollars committed to it, protection to low-income individuals needs to be balanced against fiscal control and state flexibility. The impact of a block grant is highly dependent on the formula by which the federal funds are allocated to the states, the extent to which states are required to match federal funding, the degree of flexibility given to individual states over the use of funds, and ultimately on the

decisions made by individual states about how they use the federal dollars. By capping federal contributions and eliminating the individual entitlement to coverage, a block grant leaves both states and their low-income residents vulnerable in times of economic downturn or growth in the poverty population.

An alternative approach is to retain the existing entitlement nature of the program, but provide states with greater flexibility over program eligibility, benefits, and provider payment. Federal savings could be accomplished by reducing federal matching rates, setting limitations on the rate of growth per beneficiary to allow for enrollment growth, and redistributing and limiting spending for disproportionate share hospital payments. This approach builds on the current framework of Medicaid and preserves its safety net role, while providing states with the broadened ability to restrain program spending.

Conclusion

There are no simple solutions to reducing the cost of providing care to the over 36 million Americans who now depend on Medicaid or the millions more who fall just beyond its reach; there are just hard choices. Changes to this program will affect one in eight Americans—those who are among the poorest, oldest, frailest, and most disabled of our population.

There is no magic bullet or painless solution. Broadened use of managed care requires time to implement and has limited potential for overall savings unless extended to the elderly and disabled, both groups with limited managed care experience. Reductions in federal support will ultimately mean cuts in already low provider payment rates, reductions in benefits, cuts in eligibility or some combination.

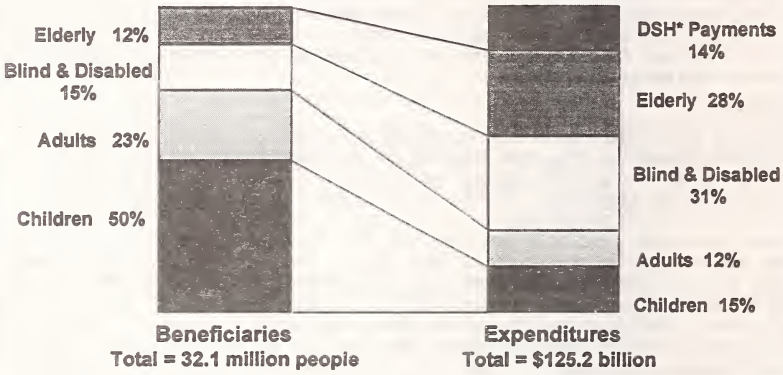
Restraining the rising cost of care for the vulnerable populations served by Medicaid without compromising the vital safety net role of the program is a difficult task. Maintaining the safety net for the children, elderly, and disabled who count on this program for their care should be a guiding principle in shaping the future of Medicaid. States can be given greater flexibility over program eligibility, benefits, provider payment, and health care delivery within the current program through a combination of statutory changes and improvements in the waiver process. Federal savings within the framework of the current program could be achieved through savings resulting from state spending reductions, changes in the federal matching rate, or limitations on per capita spending growth.

Since its enactment in 1965, Medicaid has improved access to health care for the poor, pioneered innovations in health care delivery and community-based long-term care services, and stood alone as the primary source of financial assistance for long-term care. In implementing solutions to meet the crises of today, it is important not to undo the progress Medicaid has made in providing health and long-term care for tens of millions of low-income and elderly and disabled Americans.

Thank you for the opportunity to testify today. I welcome your questions.

Figure 1

Medicaid Beneficiaries and Expenditures by Enrollment Group, 1993



* Disproportionate share hospital
SOURCE: Urban Institute analysis of HCFA data, 1994.

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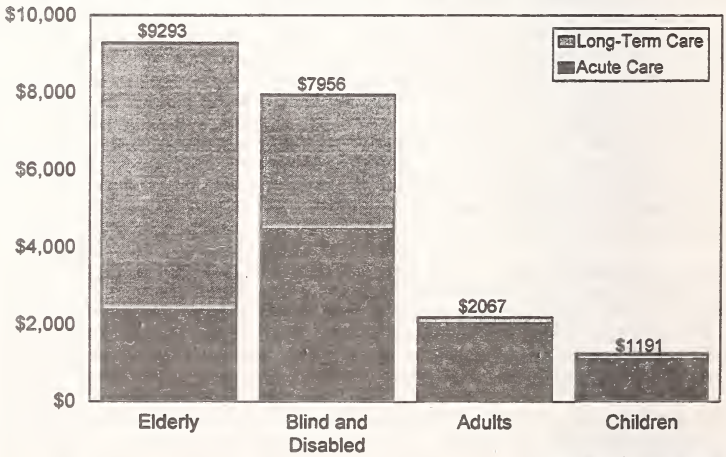
Figure 2

Medicaid Spending Per Beneficiary, 1993



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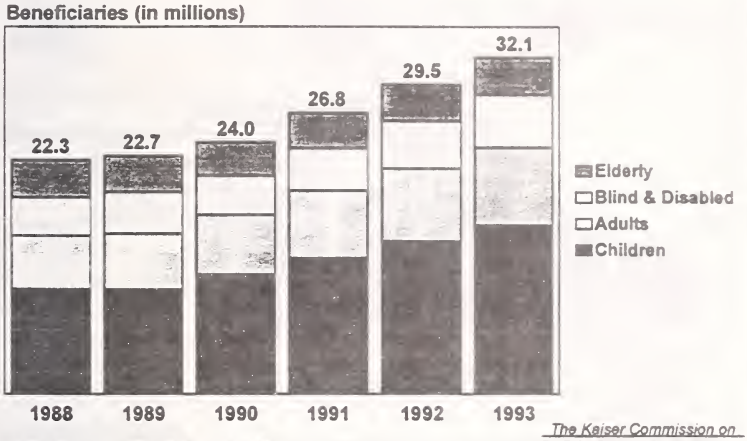
SOURCE: Urban Institute analysis of HCFA data. Does not include DSH payments.

Figure 3

Medicaid Beneficiary Growth by Enrollment Group, 1988-1993



SOURCE: Urban Institute analysis of HCFA data, 1994.

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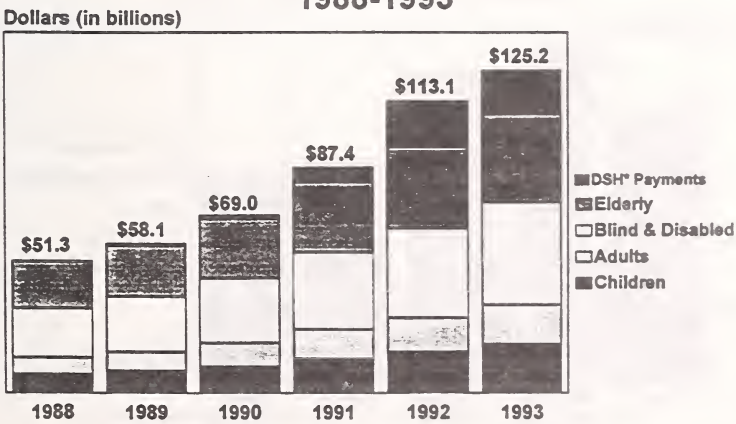
Figure 4

Medicaid Spending by Enrollment Group, 1988-1993



* Disproportionate share hospital
SOURCE: Urban Institute analysis of HFCA data, 1994.

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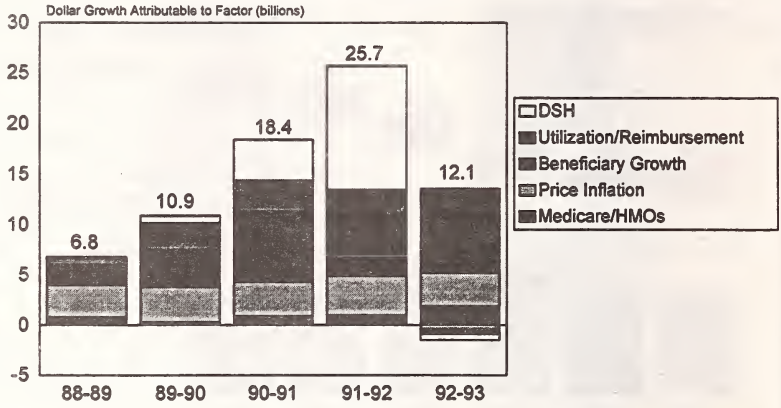
Figure 5

Factors Contributing to Medicaid Spending Increases



SOURCE: The Urban Institute calculations based on HCFA 64 data, 1995.

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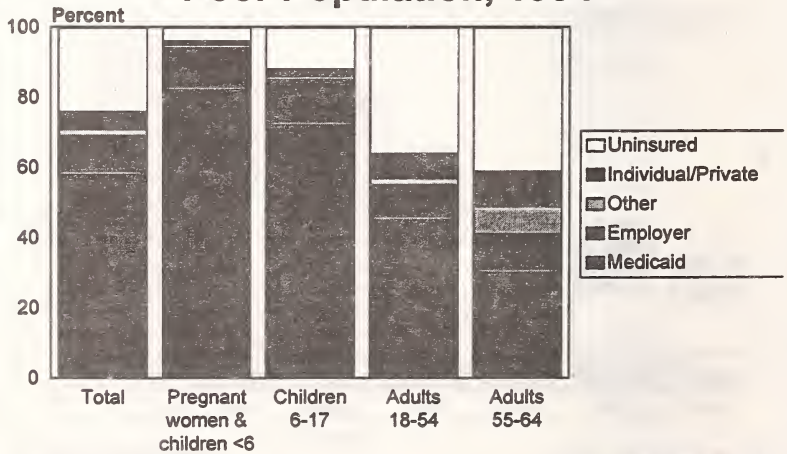
Figure 6

Insurance Coverage of the Poor Population, 1994



SOURCE: Urban Institute estimates, 1994

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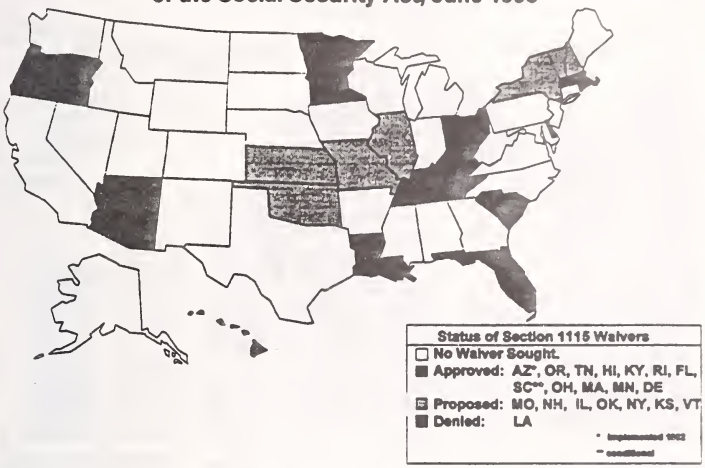
Figure 7

Statewide Medicaid Demonstrations Under Section 1115 of the Social Security Act, June 1995



SOURCE: The George Washington University Center for Health Policy Research, 1995.

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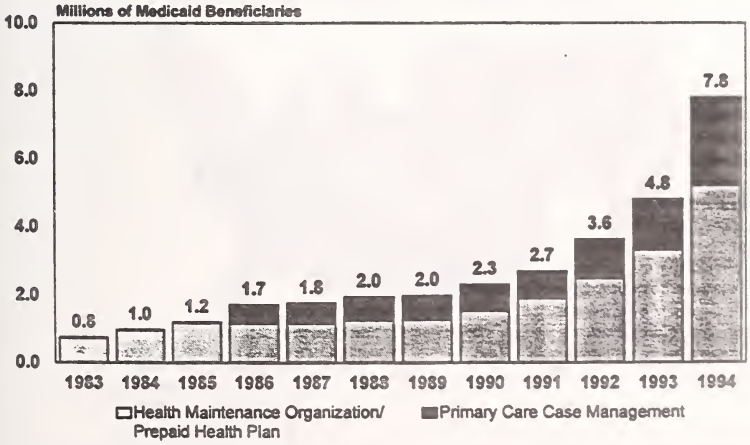
Figure 8

Growth in Medicaid Managed Care Enrollment, 1983-1994



SOURCE: Health Care Financing Administration, 1992 and Health Care Financing Administration, 1994.

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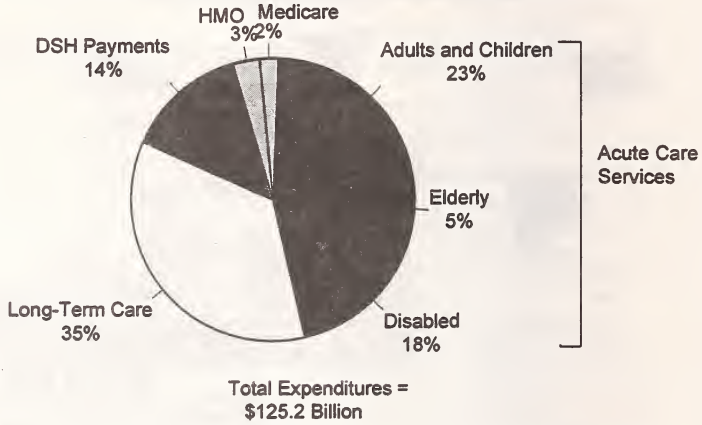
Figure 9

Medicaid Spending by Service, 1993



Note: 'HMO' represents payments for Medicaid beneficiaries enrolled in managed care. 'Medicare' represents payments for Medicare Part B premiums and co-payments for low-income elderly.

SOURCE: The Urban Institute analysis of HCFA data.

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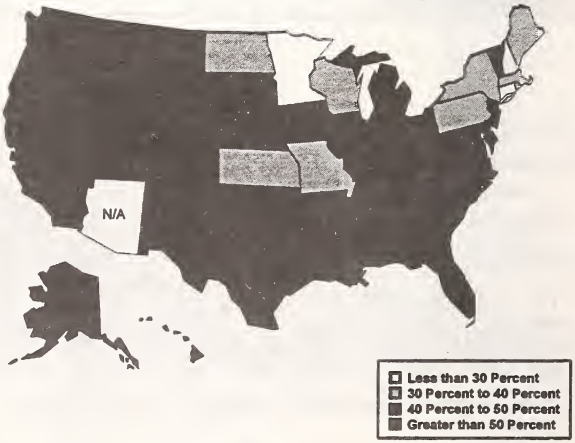
Figure 10

Medicaid Acute Care Spending as a Percent of Total Medicaid Spending, 1993



SOURCE: Urban Institute analysis of HCFA data, 1994

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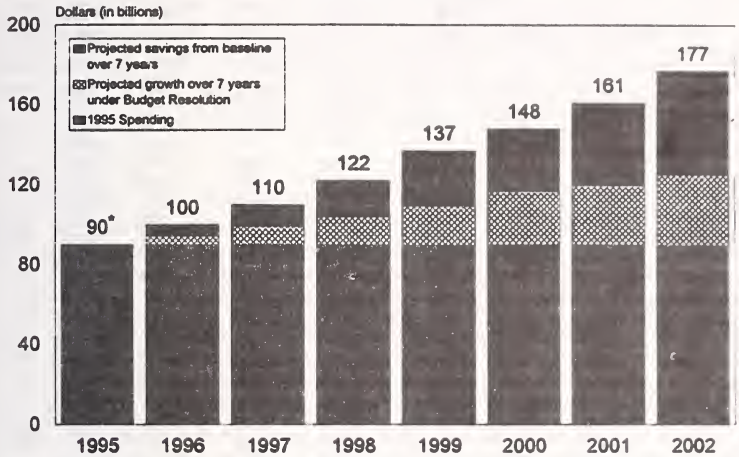
Figure 11

Projected Federal Medicaid Spending, 1996-2002



* The 1995 Budget Resolution uses an estimate of $89 billion for 1995 spending.
SOURCE: CBO 1995; 1995 Budget Resolution.

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Figure 12
Projected Changes in Federal Medicaid Expenditures, 1996-2002
Budget Resolution Block Grant Proposal
(millions of dollars)

	1996-2002				2002			
		New				New		
	Baseline	Expend.	Change	%Change	Baseline	Expend.	Change	%Change
Total	954,338	782,535	(171,803)	-18.0%	176,931	125,781	(51,150)	-28.9%
Alabama	13,823	12,090	(1,733)	-12.5%	2,485	1,943	(542)	-21.8%
Alaska	2,001	1,572	(429)	-21.4%	373	253	(121)	-32.3%
Arizona	12,903	10,231	(2,672)	-20.7%	2,436	1,644	(792)	-32.5%
Arkansas	11,081	8,636	(2,444)	-22.1%	2,084	1,388	(696)	-33.4%
California	95,663	77,631	(18,032)	-18.8%	17,955	12,478	(5,477)	-30.5%
Colorado	8,163	6,509	(1,654)	-20.3%	1,521	1,046	(475)	-31.2%
Connecticut	12,990	11,567	(1,423)	-11.0%	2,345	1,859	(486)	-20.7%
Delaware	1,728	1,397	(331)	-19.1%	323	225	(98)	-30.5%
District of Columbia	4,511	3,648	(863)	-19.1%	846	586	(259)	-30.7%
Florida	40,720	31,029	(9,691)	-23.8%	7,691	4,987	(2,704)	-35.2%
Georgia	26,050	19,957	(6,093)	-23.4%	4,900	3,208	(1,692)	-34.5%
Hawaii	2,732	2,160	(572)	-20.9%	508	347	(161)	-31.7%
Idaho	2,933	2,391	(542)	-18.5%	545	384	(160)	-29.4%
Illinois	33,242	27,123	(6,120)	-18.4%	6,207	4,360	(1,847)	-29.8%
Indiana	23,100	18,831	(4,269)	-18.5%	4,317	3,027	(1,290)	-29.9%
Iowa	7,807	6,572	(1,235)	-15.8%	1,440	1,056	(384)	-26.6%
Kansas	5,962	5,298	(663)	-11.1%	1,079	852	(228)	-21.1%
Kentucky	18,353	14,525	(3,828)	-20.9%	3,455	2,335	(1,121)	-32.4%
Louisiana	33,991	28,840	(5,151)	-15.2%	6,147	4,636	(1,511)	-24.6%
Maine	5,999	5,324	(675)	-11.3%	1,092	856	(236)	-21.6%
Maryland	13,478	10,776	(2,702)	-20.0%	2,532	1,732	(800)	-31.6%
Massachusetts	25,516	21,225	(4,291)	-16.8%	4,717	3,412	(1,305)	-27.7%
Michigan	32,153	26,218	(5,935)	-18.5%	5,992	4,214	(1,778)	-29.7%
Minnesota	14,665	12,531	(2,134)	-14.6%	2,701	2,014	(687)	-25.4%
Mississippi	12,640	10,183	(2,457)	-19.4%	2,342	1,637	(705)	-30.1%
Missouri	14,871	13,636	(1,235)	-8.3%	2,625	2,192	(433)	-16.5%
Montana	3,409	2,644	(766)	-22.5%	636	425	(211)	-33.2%
Nebraska	4,448	3,720	(728)	-16.4%	822	598	(224)	-27.3%
Nevada	2,899	2,383	(516)	-17.8%	540	383	(157)	-29.0%
New Hampshire	3,728	3,678	(51)	-1.4%	631	591	(40)	-6.3%
New Jersey	28,038	24,337	(3,701)	-13.2%	5,100	3,912	(1,188)	-23.3%
New Mexico	6,066	4,714	(1,352)	-22.3%	1,147	758	(389)	-33.9%
New York	119,527	100,604	(18,924)	-15.8%	22,034	16,171	(5,863)	-26.6%
North Carolina	29,014	22,250	(6,764)	-23.3%	5,406	3,576	(1,830)	-33.8%
North Dakota	2,491	2,109	(382)	-15.4%	457	339	(118)	-25.8%
Ohio	40,586	33,498	(7,088)	-17.5%	7,508	5,384	(2,124)	-28.3%
Oklahoma	11,074	8,824	(2,250)	-20.3%	2,060	1,418	(642)	-31.2%
Oregon	8,884	7,046	(1,838)	-20.7%	1,649	1,133	(516)	-31.3%
Pennsylvania	38,448	32,325	(6,123)	-15.9%	7,102	5,196	(1,906)	-26.8%
Rhode Island	5,465	4,604	(861)	-15.8%	1,004	740	(264)	-26.3%
South Carolina	15,252	12,971	(2,281)	-15.0%	2,756	2,085	(672)	-24.4%
South Dakota	2,380	1,985	(396)	-16.6%	442	319	(123)	-27.8%
Tennessee	24,576	19,487	(5,090)	-20.7%	4,587	3,132	(1,455)	-31.7%
Texas	61,167	50,032	(11,135)	-18.2%	11,358	8,042	(3,316)	-29.2%
Utah	5,128	4,093	(1,035)	-20.2%	960	658	(302)	-31.5%
Vermont	1,982	1,665	(318)	-16.0%	366	268	(99)	-27.0%
Virginia	13,022	10,179	(2,844)	-21.8%	2,434	1,636	(798)	-32.8%
Washington	18,203	14,484	(3,719)	-20.4%	3,381	2,328	(1,053)	-31.1%
West Virginia	13,723	10,403	(3,321)	-24.2%	2,591	1,672	(919)	-35.5%
Wisconsin	16,484	13,581	(2,903)	-17.6%	3,066	2,183	(883)	-28.8%
Wyoming	1,269	1,024	(245)	-19.3%	236	165	(72)	-30.3%

SOURCE: The Urban Institute Medicaid Expenditure Growth Model, 1995

Mr. BILIRAKIS. I thank you very much, Ms. Rowland.

When we use the word "Rowland" up here, we usually precede it with the word "doctor," and that's because there was a Dr. Rowland up here for many years, as you know.

Before we get into questions, in view of the fact there were no Democrats, members of the minority party here when I gave my opening statement, I am going to take the prerogative to invite the former chairman of the full committee, the ranking member of the full committee, Mr. Dingell, to give an opening statement at this time, and only he, and then after that we will go right to questioning.

Please proceed, sir.

Mr. DINGELL. You are most courteous.

I will not make an opening statement at this time. I will ask unanimous consent to insert an opening statement into the record at this point. I will also request, Mr. Chairman, that the responses to earlier questions by me from the Governors of the several States, at least those that have been made available to us, are inserted into the record at the appropriate place.

Mr. BILIRAKIS. Without objection.

[Responses to questions appear in the Transformation of the Medicaid Program, Part 1, hearings held June 8 and 15, 1995.]

[The prepared statement of Hon. John D. Dingell follows:]

PREPARED STATEMENT OF HON. JOHN D. DINGELL, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MICHIGAN

Today we will yet again explore the important issue of block granting Medicaid to the States. But I must say, Mr. Chairman, these hearings are becoming shopworn. We've listened to nearly three dozen witnesses over the course of almost half a year testify on a myriad of subjects related to Medicaid. Unfortunately, most have had nothing to do with detailing how the States will provide coverage to the poor when their programs are slashed by nearly $184 billion.

Mr. Chairman, we've heard how managed care can save some States money, for example. But how that translates into anything close to the $184 billion needed to offset these cuts is a complete mystery. We've heard from State Medicaid directors how Federal micro-managing costs their States millions. But we've heard nothing about how such State directors will run their programs under the proposed cutbacks in the future. We've heard from the Governors, who have been extremely long on rhetoric but almost totally absent on specifics.

Why is it that after five hearings, nearly 30 witnesses, and 40 hours of testimony we still have no understanding of how the States intend to make their plans work under the Republican plan? Because there are no details, Mr. Chairman. And that so far has been the only real lesson from these hearings: THERE ARE NO DETAILS.

I can't fault you for not having them, because I too have found their pursuit a vexing one. You recall in an earlier hearing that five State Governors testified about the Republican block-grant proposal. I thought most would have understood how their respective State would fare under the Republican plan *before* supported it. But I was wrong.

In my attempt, I requested from each a few basic details: Which formula, for example, did they propose to use to divide up the shrinking pot of Medicaid money under the Republican plan? How, under the proposed $184 billion in cuts, would they cover the citizens of their States without cutting benefits or beneficiaries? What did they intend to do under the Republican plan if their States unexpectedly faced a sharp economic downturn or a sharp increase in Medicaid-eligibles and were no longer able to turn to the Federal Government for help? Call me a maverick, but I thought these questions were somewhat essential to the debate.

And their response, Mr. Chairman? So far, I have yet to receive a single word from the Republican Governors from three of the four States including Utah, Illinois, and Michigan. The only Republican Governor that did respond, Tennessee, seems quite composed that his State may lose nearly $5.2 billion in Medicaid dol-

lars; or at least that's the way it seemed by his response that filled barely half-a-page. Then again, maybe the Republicans haven't yet told him what cuts are planned for Tennessee?

The one State that did reply with details, Mr. Chairman, was Florida. And when you learn of what the Republican plan has in mind for Florida, you will quickly grasp why most Governors won't answer.

As reported by Florida officials, the Republican plan "will devastate Florida's Medicaid program." In fact, their analysis shows that Florida will lose nearly $8.1 billion if the Republicans get their way. This will result in deep cuts in State programs and coverage which would affect hundreds of thousands. In fact, State officials reported that even if costs can be held to 1995–1996 levels—which they probably cannot—about 317,000 beneficiaries might be eliminated from Medicaid. Mr. Chairman, I find these facts about Florida most troubling. I would ask that my original request letters to all five governors and their responses be inserted into the record.

Mr. Chairman, let me conclude by saying that if my good friends from the other side really are interested in forwarding this debate, they will soon provide witnesses who will *detail* exactly how the States are going to live with $184 billion less in their Medicaid programs. They will have Governors *detail* exactly which beneficiaries they intend to cut and which services they intend to reduce to make up for these predicted shortfalls. If the Governors don't intent to resort to such draconian measures, they will *detail* exactly what efficiencies they will achieve to offset them. And finally, my Republican friends will sit Harry and Louise down at the kitchen table and they will *detail* the truth: They soon may have $184 billion less to spend on health care.

Mr. BILIRAKIS. And without objection, the opening statement of all members of this committee will be made a part of the record.

Mr. DINGELL. Mr. Chairman, also Mr. Waxman has requested that his opening statement be included.

[The prepared statement of Hon. Henry A. Waxman follows:]

PREPARED STATEMENT OF HON. HENRY A. WAXMAN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

This morning's hearing is this Subcommittee's fifth on the subject of Medicaid in the last two months.

You would think that by now, after 4 long days and 29 witnesses, we would all have some idea as to how the Republicans plan to cut Federal Medicaid payments to the States by $182 billion over the next 7 years.

Yet we—and the public—are clueless.

And so, apparently, are the States. Five Governors, 1 Attorney General, and 10 State Medicaid directors have testified so far. Not one of them has been able to tell us exactly how much their States will lose under the Republican Medicaid payment cuts, much less how their States will deal with these losses.

Perhaps this wouldn't be such a problem if we had another half a year to think this all through. But we don't. We only have until September 22 to draft, introduce, hold public hearings on, and mark up the Republican plan to achieve the deepest cuts in the 30-year history of the Medicaid program.

This would be a legislative miracle even if the Committee had nothing else to do before September 22. Of course, the Committee does have something else to do. It has to draft, introduce, hold public hearings on, and mark up the Republican plan to achieve the deepest cuts in the 30-year history of the Medicare program—$270 billion.

Yet the Republican bill to slash Medicaid spending—like the Republican bill to slash Medicare spending—is nowhere to be seen. In sharp contrast, anyone who would like to know every detail of the Republican plan to cut taxes for the wealthy would only get a copy of H.R. 1215, which passed the House 4 months ago.

With all due respect, Mr. Chairman, this is no way to run a railroad. It virtually begs for a budgetary train wreck that is not in the interest of the country or of the millions of Americans who depend on these programs.

Over 36 million Americans have coverage for basic health and long-term care services under Medicaid. After 4 hearings, 29 witnesses, and a few wheelbarrow props, the Subcommittee is finally going to hear from 3 of them this morning.

They will not talk in code, using words like "flexibility" or "mandates" or "micromanagement" or "innovation." Instead, they are going to tell us in an honest

and straightforward way what the loss of guaranteed coverage will mean to them and their families, and to others like them.

I hope my colleagues will listen closely. Because what you're going to hear is that the Republican Medicaid block grant is going to put these Americans, and 36 million others like them, into an untenable situation.

Under the Republican plan, States will be told that they will have a fixed amount of funds each year. That amount will be cut by $182 billion, or 18 percent, over the next 7 years. This will not leave enough to maintain current levels of service.

The Republican plan will create a zero-sum game. The only way that a State will be able to increase the amount of help that it gets from the Federal Government is to take funds away from another State. If high-growth, low-benefit States like the Chairman's State of Florida and my State of California need additional Federal funds, they will have to take them from other States.

Obviously, that's a political dead end. So is innovation. In the "race to the bottom" that block grants will start, any State that maintains, much less expands, coverage will be inviting an in-migration of medical refugees from other States that have terminated coverage to protect themselves financially.

In short, States will have nowhere to turn but against their own citizens.

Because even after they have ratcheted down on payments to providers and cut back on optional services and enrolled everyone in managed care, States will *still* not have enough Federal funds to maintain current coverage. Instead, they will have to terminate coverage.

Whose coverage will they terminate? None of the Governors or State Medicaid Directors we have heard from so far has been able to tell us.

But one thing is certain. The States will have to choose among the three populations represented here today: the elderly, the disabled, and mothers and children.

And just like it traps the States, the Republican Medicaid budget traps these beneficiaries in a zero-sum game. If one group's coverage is saved, another's will be lost.

I do not believe that the American people fully understand the implications of the Republican Medicaid cuts. But I can tell you one thing: the beneficiaries who are testifying here today understand them.

We should all listen carefully.

Mr. BILIRAKIS. By all means, sir. All members of this committee will have their opening statements made a part of the record.

Thank you, sir.

I would ask you both, Ms. Checkett on behalf of Missouri and Ms. Rowland on behalf of the Nation, if you will, in past hearings we have heard from a number of State Governors and, as you know, Medicaid directors. Almost unanimously, they have voiced their goal of realizing better access, improved health outcomes, cost control and budget predictability in their Medicaid programs, and, as you may know, these are the very same goals that are guiding us as we work to improve the Medicaid program.

We are also very well aware of what the consequences will be if we fail. The program will remain costly, complex and highly bureaucratic.

In your opinion, Ms. Checkett, what will be the financial and flexibility consequences for Missouri and, Ms. Rowland, and the Nation if Medicaid is not reformed?

Ms. CHECKETT. For the State of Missouri, if we do not have changes in the current structure which would obviously include changes in who is eligible and the rates at which we pay benefits, we will move from a program that is now 25 percent of our State budget to something that will be much closer to 35 percent of our State budget based on current projections.

Mr. BILIRAKIS. Let me ask you before we shift over to Ms. Rowland, in terms of those, the eligibility, you are as concerned, I like to think even more concerned than we up here, in terms of the

needs of your people. You are certainly closer to them. How would you handle the eligibility?

What I am saying is, the concern on the part of many up here is that the States will basically shut their eyes, maybe, to an awful lot of the needy and that sort of thing. We will probably hear a lot of testimony to that effect later on today.

What was your response to that?

Ms. CHECKETT. First of all, we have an extremely cumbersome eligibility program. There are well over 40 different ways in which people become eligible for Medicaid yet it is also possible to have literally no income and not be eligible for Medicaid because you don't fit in one of those 42 boxes.

We will first look at simplifying drastically Medicaid and, really, in my State probably just making much of it income-based. But the reality is that under the current projections for reductions in Federal Medicaid spending, at some point probably in year 2 or 3, we will be faced with making decisions about who we will no longer cover and that is because we simply will not have the dollars to sustain the current coverage in our State and we have chosen to cover almost all of the groups eligible under Medicaid. And that is the simple reality of it, is that we will have to at some point have to make a decision about not covering individuals.

Mr. BILIRAKIS. Do you feel that we may be heading or in fact we are heading toward that end even under the current system? You mentioned raising 25 percent of your budget up to 35 percent if we continue to go this route?

Ms. CHECKETT. Well, under the current system, we would just continue to put the State required funds forward on the Federal mandates so we really don't have—other than pulling back on optional coverage for pregnant women which my State doesn't want to do, much of that 25 percent and the projections for growth up to 35 percent are Federal requirements so we would continue to put the State funds forward which the general assembly does not like in my State but we are not saying we are not going to cover people.

The reality is if we are going to pull back and redesign, part of that decision will include not covering individuals who are now in the program. I would say at the same time that it is also possible that in Missouri we would cover people who aren't eligible now. For instance, those who have absolutely no income but don't fit in 1 of 42 boxes.

So we will undertake a serious overhaul of the program. Again, I think our dilemma will be trying to do that in a thoughtful manner, considering the time lines we are looking at, which is October 1995. It is hard to be thoughtful in several months.

Mr. BILIRAKIS. Thank you.

Ms. Rowland?

Ms. ROWLAND. One of the problems with Medicaid is that it is, in fact, the Nation's safety net. So as we see declines in health insurance coverage in the private sector, as we see growth in the poverty rates, Medicaid has been there to fill in, to help with the AIDS epidemic, to help with the needs of the elderly and the disabled.

So one of the problems when you look at the program from the perspective of reforming it, is that it is filling in gaps that show

the flaws in our overall health care system and if you close Medicaid as that safety net, as that safety valve, you leave nowhere to turn for the individuals who are today uninsured and for many of the most disabled and vulnerable in our society.

So that the real goal in reforming Medicaid ought to be to first protect those individuals who have nowhere to turn and to maintain the safety net but find more efficient and effective ways of delivering both the services and of making people eligible.

I agree totally with Donna that having individuals who have to fit specific categories and can't enter the program because they are low-income is, indeed, a problem. Yet to expand Medicaid under the current program to allow all individuals that are income-related to come onto the program has always implied an additional cost. It is what many States have done through their 1115 waiver programs and I think it warrants further examination.

But, most important, I think you have to look at what happens to the uninsured and to the low income and to the highly disabled if they don't have a safety net program and they can't get coverage through private insurance or the work place.

Mr. BILIRAKIS. Thank you, Ms. Rowland.

Would the gentleman from Michigan, Mr. Dingell, wish to inquire?

Mr. DINGELL. Mr. Chairman, I have some additional questions and I ask unanimous consent that the record remain open for the receipt of those which I would like to direct to our panel.

Ms. Rowland, the current amount of Federal Medicaid per person in several States is as follows in 1993, Michigan, $2,088 per person; New York, $4,997 per person; Texas, $1,526 per person; California, $2,088 per person. Each State is required to have a different level of matching funds with regard to this.

Now, in New York, if there is a 4 percent increase, on their share, that will be significantly greater than a 4 percent increase on the $1,526 per person in Texas. Now, are we not also confronted with a problem where the number of beneficiaries and potential claimants is going up, the percentage of Federal dollars per beneficiary will be lower in States where the number of beneficiaries is staying flat or laying down? Doesn't this set up what is basically an unfair situation and what comments or suggestions do you have?

Ms. ROWLAND. I think that anyone looking at the current distribution of Medicaid funds would see very different patterns based primarily on different choices that different States have made with regard to how much they pay providers, with regard to who they cover under the program, with regard to how they distribute their funds between acute and long-term care.

If you base future formula allocations on the current distribution, you lock in all the historical patterns and inequities that those patterns imply and you provide no growth room for States that were moving up to become more comprehensive in their coverage.

Mr. DINGELL. Or more populous.

Ms. ROWLAND. Or more populous or having more low-income people.

Mr. DINGELL. Or where there is an economic downturn which creates a sudden influx of eligible persons because of an economic downturn; is that right?

Ms. ROWLAND. No way to account for that if you base it on history.

But, moreover, it is also important that depending on how your current funds are distributed, you may have more difficult choices about how to restrain spending under that program so if a lot of the dollars in your current Medicaid program are in, say, long-term care, reducing those expenditures may, in fact, be much more difficult than achieving savings through, perhaps, greater use of managed care for acute care services.

Mr. DINGELL. Is this a fair way of distributing Federal dollars to the several States? How should the formula for deciding the amount of Medicaid money for each State be generated?

Could you give me some specifics, just briefly now, administration then in greater detail later if you please, by letter of response through some correspondence on this issue?

Ms. ROWLAND. I would certainly be glad to provide you with the many analyses that we have been trying to do of the distribution of Federal funds under the Medicaid program. If you base the existing distribution on existing patterns, I believe it is inequitable and will lock into place many of the current inequities in the program.

If you, instead, base the program more on a per capita cap or on some kind of a relationship of individuals covered in service distribution, you would provide greater equity and allow for some program growth. However, in addition to that, you might want to provide greater incentives or greater dollars to States with larger numbers of poor people because, currently, the formula doesn't take into account the current distribution where poor people live and where all the growth is in the poverty population.

Mr. DINGELL. It is also true that this is, I guess, a background of about $182 billion in cuts from the Federal Government's expenditures to the several States; is that right?

Ms. ROWLAND. Right. With a cut, you don't have much room to sweeten the pot in redistributing the dollars.

Mr. DINGELL. Now, Ms. Checkett, will you tell us what States are going to do if we have a recession such as occurred in the 1980's? How will the States address the problems of increased need for Medicaid when they can't come to the Federal Government for help in getting through a fiscal crisis? How are we going to address the problem that, for example, certain States such as California, more recently Texas, are having or have had periods of economic downturn recently? And Michigan had a very severe period of economic downturn in the early 1980's.

Where will States like that go to get redress under a plan which does not afford flexibility to the Federal Government or to the States in getting additional Federal funds to deal with the significant program of economic downturn?

Ms. CHECKETT. That is why our recommendations include the establishment of a contingency fund to deal with specifically issues like that. But I would also say that right now when we have economic downturns, Missouri had one at the same time Michigan was having that in the early 1980's and a smaller one, lesser, in the

1990's, the current program, we are still required to put State funds in and as our case loads are going up because, as I say, when business is bad our business booms, and so we have less State dollars to put into a matching program and yet we have more eligibles coming onto the program. So there is a dilemma at the current situation.

Mr. DINGELL. My time is up. Mr. Chairman, I just want to ask one more question though.

You have said, Ms. Checkett, in your testimony, and I quote now: "States should not be subject to any maintenance of effort requirements under Federal block grants".

That means that the States, if I carry that to its logical extreme, it means the States should then receive whatever they want under the grant and have no responsibilities to spend any State money at all to match the Federal requirement. Isn't that a fair interpretation of what you have said to us?

Ms. CHECKETT. I think that is a fair interpretation.

Mr. DINGELL. How would you justify that?

Ms. CHECKETT. It has been a longstanding position of APWA that, under block grants, States should not have maintenance of effort. I would say that what's happened to us in recent years, because of the mandates, we have been forced to put much more money into Medicaid in some States than that State would have chosen and to simply be locked in at the amount of money we now have obligated we feel we need to have the same latitude that Congress is wanting to enjoy at this point in time, which is Congress wants to pull back on your funding. We feel States need to have the option to pull back as well.

Mr. FRANKS [presiding]. The gentleman's time has expired.

The Chair at this time will yield to himself.

I would like to pose my first question to Ms. Checkett. I do apologize for missing your opening remarks and you may have touched upon this point already.

You mentioned, though, in your written testimony that the section 1115 waiver process, you alluded to that process, to the best of your knowledge, how much has this lengthened and complex process cost States in terms of dollars, staff time and opportunities?

Ms. CHECKETT. I am sorry, sir. Are you referring to the application process itself?

Mr. FRANKS. Yes, the application process itself, the waiver process.

Ms. CHECKETT. I don't have a dollar estimate to give you. I can tell you it has been an extraordinary amount of time. States have undertaken a series of public hearings. Writing the waivers in my State, it took us about 9 months to write our waiver; they are very complex components of Federal calculations on funding and savings to States. So it has been a very lengthy process and it has moved very slowly through the Federal Government approval process.

Mr. FRANKS. It is hard to put a dollar figure on how many dollars this would equate to as far as——

Ms. CHECKETT. I would be comfortable in saying millions, especially when you consider the many States who now have 1115 waivers before, it is surely that. With States, when you have just

so many FTE, so many staff, what happens is a staff person who could work on one assignment but can't work on another and that's the real cost to the State, is what else we can't do.

Mr. FRANKS. Okay.

I am an advocate of the use of managed care for Medicaid, and I wanted to get the opinion of both of you as to why we should not proceed down that road. The positives and/or negatives of doing so.

Ms. Checkett?

Ms. CHECKETT. I think we have to proceed down that road and I don't think it is a bad thing to do either. I think that done well, Medicaid managed care can control the growth of the costs of Medicaid and can actually improve access. Again, done well, with the proper assurances in place.

There is much to be learned about managed care with the elderly and disabled and that is an area that is really a frontier for States yet it is where 70 percent of our current Medicaid dollars are so we have a lot to learn.

The challenge is doing that in a manner that protects consumers while States go about achieving the savings we obviously need to achieve in the very near future.

Mr. FRANKS. Ms. Rowland.

Ms. ROWLAND. With a quarter of the Medicaid population currently enrolled in managed care, we are already gaining a lot of experience with what works and what doesn't. One of the lessons we see is that if you move too rapidly into managed care situations without an adequate infrastructure, no plans that are really available and if you don't have adequate monitoring, you can have a lot of problems and abuses especially with a low-income population that has greater health needs than others in the society.

What is most troubling about the push to managed care is not the concept itself but the rapidity with which people want to move to managed care and the movement, as Donna mentioned, of people who are elderly and disabled for whom we have little experience with how managed care would work and if you try to move too quickly and achieve savings in managed care too dramatically, you will ultimately compromise the care these individuals get.

One of the real problems with Medicaid is Medicaid has not been an expensive payer in the health care system. It has, in fact, paid providers, especially doctors, relatively little in the past. So the kinds of discounts that we have been able to see in the private sector when one moves from a fee-for-service to a managed care situation are not necessarily going to be there in the Medicaid program because of Medicaid's already low payment rates. So it is just a matter of not trying to achieve too much too quickly and overpromise on the savings.

Mr. FRANKS. Are you fearful when you look at the overall package for the indigent, are you fearful that the indigent may shop around and go from one State to another State and that Governors would potentially try to exert themselves in a way in which they are reducing their allocation for various benefits to the point where the indigent would say, well the State of Connecticut is a lot better than the State of New Jersey, which is a lot better than the State of Missouri, et cetera.

Are you fearful of that type of thing happening in our system today if we should go ahead in this manner?

Ms. ROWLAND. I think you could certainly see some migration across State lines. We have seen some in the past but there have never been the great incentives that there are today but we do know that in some cases individuals have moved from one State to another because of improvements in one Medicaid program.

I think that you are particularly, coming from New England, in a problem because those States are so close together.

Mr. FRANKS. Yes.

Ms. Checkett?

Ms. CHECKETT. My experience with that is more anecdotal than factual. I can tell you we have a very good transplant program in Missouri and we have had people call wanting to know if we cover different transplants because they are going to move to Missouri if we do. And that actually probably raises a larger question of inequities in coverage and the fact that Medicaid is actually a very generous purchaser of various services, things that commercial insurance products frequently don't cover.

So that does happen and I do believe——

Mr. FRANKS. How do we prevent that? Is it something that you cannot prevent, or should we be trying?

Ms. CHECKETT. Right now we can't prevent it because we can't have restrictions on the amount of time someone must have resided in your State in order to receive public assistance, so that is a Federal statute that prohibits us from doing anything about that.

Mr. FRANKS. That is from a short-term perspective. Obviously, from a longer term perspective, if a person is looking at some of the changes that we are looking to adopt, they can also plan for a longer term type situation versus just planning for what would happen in the next, you know, 30 days or 60 days or whatever.

Ms. CHECKETT. I think if there become especially even greater disparities among programs than there are now that that will happen because people do what they can and use what skills they have, whatever they are, to take care of themselves and their families and I think that will happen.

Mr. FRANKS. Do you feel that having certain minimum standards established by the Federal Government while still allowing the States to exert their flexibility could be a way in which we could address that concern? I pose that to both individuals.

Ms. ROWLAND. Certainly a minimum standard such as required coverage of all children under the poverty level would help to keep people from having incentives to move from one State to another to obtain coverage for a very critically ill child. Certainly it is also important to think about having such standards if you are going to require individuals to be in the workplace who have currently been able to get health insurance coverage through Medicaid. There is a strong incentive there for people to stay on Medicaid today in order to get health insurance for their families.

Mr. FRANKS. And my last question would be on the for-profit managed care operations and the not-for-profit, nonprofit managed care operations. Do you have an opinion about the two of them?

Ms. ROWLAND. I think in some of the States where you have seen the introduction of for-profit managed care plans, you are seeing a

great deal of the money that used to go directly into paying for services of providers being taken off the top in the form of some of the profits to the for-profit plans. And I think you have to be very careful if you are squeezing down on the amount of money available per low-income child or family, that you not end up giving most of those dollars to administrative costs for entities that are middlemen between the patient and the provider.

Mr. FRANKS. Is that to say that you do have a problem with for-profits?

Ms. ROWLAND. I think that you really need to look at the contracting arrangements and at the way plans work. I am not sure that some of the nonprofits don't also have larger administrative costs.

Mr. FRANKS. I would agree.

Ms. ROWLAND. But I think you really need to be very careful there about not losing service dollars.

Mr. FRANKS. Not that the Chair should be agreeing with the witness, but I kind of agree with that point.

And, Ms. Checkett?

Ms. CHECKETT. I would agree. I think it is not a question of profit or not-for-profit. I think States must carefully set up financial requirements in their contracts that allow them oversight. Although I do know that health plans and HMO's are making a good profit off Medicaid. There are many historical Medicaid providers who have also made a good profit off of Medicaid so the question really is that balance. Is it appropriate to make a profit, people will only work for profit, but how much less is going into services and that is what we need to look at.

Mr. FRANKS. Thank you very much.

The Chair would yield to the gentleman from Ohio for 5 minutes.

Mr. BROWN. Thank you, Mr. Chairman.

Governors, several Governors, have been in here and with the exception of the Governor of Florida, they have advocated that States have complete control over the Medicaid program, as you know. As you know, with essentially no strings attached, no minimum standards. They simply want the money designated, they use the term "for health care services."

About 2 months ago I visited a hospital just outside my district in Cleveland called Health Hill Hospital for Children, and that hospital, 85 percent of those patients that were there, they are the sickest children that may have suffered head injuries and they are children that have the highest cost of health care, all of that.

Eighty-five percent of them are depending on Medicaid for their coverage. They are not necessarily children of poor families; they are often middle class families with huge health care costs.

Comment both of you, if you would, on the Governors' request for basically block grants with no minimum standards for "health care services" in light of the fact that we are talking about the sickest children in that case and we are talking about much of Medicaid moneys going to the elderly in nursing homes. How will that change, what will that mean if the Governors have their way that way?

Ms. ROWLAND. I think that you pointed out the real problem and the real dilemma in moving to any kind of a block grant and, on

top of having this competition between the sickest but also often the most voiceless in society against some of the more powerful interests that would come before some of the State legislatures, I am concerned that the allocation of dollars would leave some of the most vulnerable unprotected under a block grant type of approach which is why I continue to advocate for maintaining an individual entitlement to services for the poorest of the poor and the sickest of the sick.

Mr. BROWN. Ms. Checkett?

Ms. CHECKETT. The States in general call for flexibility in this area because of the differences in States. Some States have very high proportions of elderly, some States have high numbers of disabled or children. But I think you have identified a real concern that is a fair one because there will be tremendous pressure.

As I look at it, if I had to make a decision today about how to implement these proposed Federal reductions, it is going to be a choice between the elderly in the nursing home, I think States will choose to cover very disabled children. The ones I am concerned about are the children who aren't sick. What they need, they are low income, they need access for preventive care services. And if you have a very limited pool, I think the inclination of States will be to go for the people who are very, very sick because that is the immediate crisis and we will have to walk away from the great progress we made over the past few years about funding preventive services for low-income children. And I think it is a real dilemma. But States do feel that we need flexibility because we are so different.

Mr. BROWN. Where does managed care save money then? If you segregate out nursing home services where managed care apparently can't save much money and then you block out or segregate out the sickest children in hospitals like Health Hill, is that where the money is saved? Managed care is always lauded as the way to get better preventive care and to get those families where the mother doesn't always or the father doesn't always bring in young children for immunizations or where the prospective mother the pregnant woman is not bringing her children in or coming in for prenatal care, that seems to be, from what I can understand, where this works the best.

But you are saying that you take out those two big blocks, there is no money left and managed care falls flat on its face then?

Ms. CHECKETT. Well, I think the savings with managed care are marginal to begin with. I think it is a better system of financing and accessing services. In the first year, a State can expect to save between 5 and 10 percent and 10 would be very lucky. That is a big one-time savings and after that you have to start increasing the managed care rates just like you increase rates for health care inflation to other providers and you do see a shift to more appropriate services, a shift out of hospital care. But I am concerned that there is a big perception that one of the ways States can deal with the magnitude cuts is with managed care. That will be one of our tools. That is not remotely close enough for us in savings to be able to deal with the magnitude of the proposed cuts.

Ms. ROWLAND. If you look at the current spending under the Medicaid program, about 23 percent of Medicaid dollars go for serv-

ices to low-income families that are acute care related. If managed care saves about 10 to 15 percent over fee-for-service for that portion of the Medicaid budget, you are talking about overall savings of about 1 to 2 percent. If you bring the disabled in, that is another 23 percent of total spending and another maybe 1 to 2 percent.

So we are really talking about only 3 to 4 percent reductions overall under the most ideal managed care situations. It is not the solution to reducing spending for the Medicaid covered population.

Mr. BROWN. So these cuts are clearly going to be felt by large segments of the population, no doubt?

Ms. ROWLAND. They will have to be and, in addition, I think it is important to point out that while we talk here about $182 billion in reductions in Federal spending over the next 7 years, depending on what requirements are placed on States in terms of a maintenance of effort, you could also see a reduction in State spending along with the Federal spending which could reduce overall spending on the low-income population by twice as much as the $182 billion, which would make the cuts in Medicaid even greater than those being proposed for Medicare.

Mr. BROWN. Thank you, Mr. Chairman.

Mr. STEARNS [presiding]. The gentleman from Wisconsin, Mr. Klug.

Mr. KLUG. Thank you, Mr. Chairman.

Ms. Checkett, if I could go to you first, one of the things in your recommendations to Congress in terms of repeals, in fact the first thing, was repealing the Boren Amendment. Could you please indicate for me what kind of impact that has had on the State of Missouri and what repealing it would do to make your life easier?

Ms. CHECKETT. It would make my life considerably easier. The Boren Amendment, unfortunately because of the way courts have interpreted it, States have lost Boren suits because we didn't follow correct procedures, frequently getting those rulings without any discussion on the adequacy of the rate. So we spend elaborate time now trying to make sure we have the appropriate procedure process.

We have had association-wide suits under Boren, we have also had suits from specific hospitals. It has been a wonderful way for all the attorneys in my department and other attorneys to be busy suing each other. I don't think it has provided much for the Medicaid client and it has been a lot of work for the State. I think it is very unfortunate that the findings in those court decisions have frequently not even looked at the actual adequacy of the rate.

We feel that there have to be other measures for appropriate State payments. I think that if a provider signs a contract with a State, they are accepting the State rate and that should be it. We have never made anybody sign a contract to be a Medicaid provider. So we feel it would not only reduce administrative problems but it would help us spend our dollars wiser as well.

Mr. KLUG. Ms. Rowland, any comment on the Boren Amendment?

Ms. ROWLAND. Certainly one of the reasons many States have moved to managed care and one of the aspects of managed care is to get around the Boren Amendment because then the plan negotiates private payment rates with the hospitals.

I think that clearly you want some standard so that providers are paid reasonably. The Boren Amendment has ended up in a lot of court action although savings from repealing the Boren Amendment are only estimated to be in the $2- to $3 billion range, so it again is not a major component of the spending; it is more an annoyance to the States and a cost for the litigation.

Mr. KLUG. But I want to follow back on something you just said about managed care: in your estimate it only manages to save the system 3 to 4 percent if you add the two components you talked about. But if what we are really trying to do here is to reduce the growth of Medicaid and Medicare spending from 10 percent to 7 percent, if you can save 4 percent, we have already hit our target. So you may not necessarily solve the problems generally, but you have just done a great deal to reduce the increase in the growth of spending.

Ms. ROWLAND. No, sir, you haven't hit your target with that because going from a 7 to a 4 percent growth rate is an overall 18 percent cut in total program spending, so you are still substantially below where you would have to be in order to achieve the full range of savings from going to managed care.

Mr. KLUG. You just lost me. If what we are trying to do is stop the growth rate from 10 to 7 percent, you just told me it could save the system 4 percent.

Ms. ROWLAND. It doesn't save 4 percent in growth; it saves 4 percent in overall dollars. It saves about $1 to $2 billion a year and you are trying to achieve savings of $182 billion.

Mr. KLUG. You were talking earlier about the cuts and some of the implications. Don't you think clearly that means testing is part of this? That if you look at Medicaid, for example, and the program aimed at seniors that if we are going to talk about fairness, is it fair to ask seniors who can afford to pay more, to pay more?

Ms. ROWLAND. Medicaid is already a means tested program and so individuals, to be eligible for the program, either have to have low incomes and low assets or already be on one of the Federal welfare programs like the SSI program.

Clearly, one of the problems has been that we have had people who are extremely low income and not eligible for the program because of some of the categorical restrictions on who can be eligible and not but it is a means tested program.

Mr. KLUG. And you don't think it could be changed in any way, in terms of means testing? Can't be improved, can't be tightened?

Ms. ROWLAND. I think you could clearly move to eliminate some of the categorical restrictions on program eligibility and have a more direct income-related application for benefits under the program. I think one ought to look also at the assets test for the low-income families on the program.

We did some work with the APWA several years ago that found that States were spending more money looking for the asset determinations for low-income families than they were really recouping in keeping people off the program.

So I think there are a number of ways you could streamline and improve the eligibility for the program but I think it is and will remain a program that is means tested and focusing only on low-in-

come people as long as you keep those tests in place for the program.

Mr. KLUG. Ms. Checkett?

Ms. CHECKETT. I think that there certainly, and we hear a lot about individuals who are of middle and upper income who shelter assets and become Medicaid eligible for nursing home care. As a matter of fact, there is a new bestseller, you might want to buy it for $27, you can get a wonderful new book called "Avoiding the Medicaid Trap" that talks all about Medicaid and transfer of assets and actually is highly outraged over the 1993 provisions that was passed in OBRA 1993 that tightened some of that down.

That does happen and I think one thing that we will do in my State and in others, we will continue to really tighten up ways in which individuals hide assets and unfairly become eligible for Medicaid coverage for people who are in nursing homes.

Mr. KLUG. Thank you much for both your answers.

Mr. Chairman.

Mr. STEARNS. Thank you.

Now, my colleague from Georgia, Mr. Norwood.

Mr. NORWOOD. Thank you, Mr. Chairman.

Ms. Rowland, I am a little interested. You said that the poverty level had been on the increase. Does that increase include illegal immigrants?

Ms. ROWLAND. To the extent that they are counted in census data, they would be included in the numbers of poverty in the United States. However, it is my understanding that much of our census data doesn't always pick up the illegal immigrants into the country.

Mr. NORWOOD. We don't then know what percent of increase may have been caused by that?

Ms. ROWLAND. We don't know specifically what percent has been caused by illegal immigrants but we do know that there has been an increase in poverty among American citizens as well.

Mr. NORWOOD. Ms. Rowland, I just want to ask a personal observation. I am curious how you might think about this.

Do you feel that health care in this country for our citizens is a constitutional mandate?

Ms. ROWLAND. I feel that health care ought to be a right for all American citizens. I feel that it is part of protecting the population and protecting all of us against some of the diseases that are carried by individuals who go without health insurance such as tuberculosis. So I think there is both a personal and a public health responsibility to try and ensure and protect health care in the country.

Mr. NORWOOD. So it is really for you not that we, as a moral people, have a responsibility to help those who are less fortunate than we; it is purely a constitutional mandate in your opinion that we have to do that?

Ms. ROWLAND. I feel that it is something that we as a moral people ought to do and it is something that we as wise, public health people ought to do to protect the safety of all citizens.

Mr. NORWOOD. So it is really just a good idea; it is not mandated?

Ms. ROWLAND. I think it is an important concept and I don't know that the Constitution specifically names health. It certainly doesn't. But it certainly talks about preserving and protecting the public welfare and one could consider health to be a very important part of the public welfare.

Mr. NORWOOD. My presumption is that you haven't answered the question. But that's all right.

How do you think we are doing in Medicaid as a Federal Government? Do you think we have been successful?

Ms. ROWLAND. I think Medicaid has been a very successful program if you measure it against the standards of what it has done to help improve health care services to low-income people, to the elderly and the disabled. I think it has enabled, in many ways, the Medicare program to work for the poorest of the elderly and disabled who are on that program by helping to pay Medicare premiums, cost sharing deductibles so that all elderly people can benefit from the Medicare program. And I think it has been a particularly important program to help the most disabled individuals in this country who would otherwise be without insurance and their families would be impoverished by their medical bills.

Mr. NORWOOD. There is no doubt that it has helped a lot of people, so you would say that we have done a great job as a Federal Government in Medicaid, and we probably ought to continue on the path we have been going and ignore the idea that perhaps we ought to block grant it back to the States; that what we have been doing is the way to do it?

Ms. ROWLAND. I think we have had a partnership with the States in working on the Medicaid program. Certainly a lot of the decisions about how the program operates have been made by the States. I think there is always room for improvement in any program but I don't think that you should throw out the baby with the bathwater.

Mr. NORWOOD. Georgia next year, as I understand it, will receive, if the formula stays the same, the same amount of money in 1996 as it did in 1995 but a 5 percent increase. Would you say that next year Georgia will get more money or less money than it did in 1995?

Ms. ROWLAND. In absolute dollars, it will get more money than it did in 1995.

Mr. NORWOOD. I ask you that question because I feel like my job is to follow Mr. Dingell around and to say when you make more dollars available that's probably not wise to use the word "cut" in dollars and I noticed that you seem to agree with him. And my view is that more money will flow into that State next year, 1996, than it did in 1995 and I know some folks call that a cut in the Beltway but folks at home don't seem to think of that as a cut; they seem to think of that more of my tax dollars is going into the program, not less of it.

Having been a provider in Medicaid, I was interested to note that your comment that actually the providers receive very low payment rates in Medicaid over the years. In conclusion I will mention to you that prior to Medicaid, many providers did all that they could do to serve and help people who could not afford to pay, often times as much as 20 percent a day. And when Medicaid showed up in our

world, it paid providers very little, and that was acceptable. Most of us felt we needed to do this as a public citizen, and as it continued to have less and less funds because we added more and more people to the program, providers basically came to a point in many cases that they simply could no longer pay for health care for poor citizens that the government couldn't really afford to pay.

I appreciate the fact that you noted that the providers are paid very poorly and in many cases at cost and in more cases less than cost and Mr. Chairman, could I ask just one last question?

Mr. STEARNS. All right.

Mr. NORWOOD. I would be curious to know if you feel that providers of this country should be mandated by Federal law to treat Medicaid and Medicare patients?

Ms. ROWLAND. They currently aren't mandated today to do that; it is a voluntary program which is why the participation rates have often been low.

I believe that the country needs to provide financing to its low-income individuals so that we can have people gain access to care without requiring providers to see them.

Mr. NORWOOD. So you would not vote to make that a mandate, a law?

Ms. ROWLAND. I don't think you can force providers to see patients they don't want to see.

Mr. NORWOOD. Good idea.

Thank you, Mr. Chairman.

Mr. STEARNS. Thank you, Mr. Norwood.

My friend from Florida, Mr. Deutsch.

Mr. DEUTSCH. Thank you, Mr. Chairman.

Just in terms of a followup question to what Ms. Rowland mentioned and I think that is really the crux of the issue for many of us—Dr. Norwood, sorry—and that really is a question of increases. Again, if you want, we can go through the same thing.

In the instance of Florida under this proposal, Florida would be receiving less or more absolute dollars than they received last year?

Ms. ROWLAND. Florida would receive more absolute dollars than it did last year but it would have to stretch those dollars farther to provide the kind of coverage that it did last year.

The nature of a baseline is that it means what would it cost to cover the same number of people next year as you did last year.

Mr. DEUTSCH. Right. If we can kind of walk through that because I think Georgia really is very similar to Florida in terms of growth issues and, in some ways, even demographics. That in terms of a per person dollar allocation, would that be increased or decreased of someone on Medicaid?

Ms. ROWLAND. Of someone on Medicaid? It would probably—it depends on——

Mr. DEUTSCH. Let's say what's been discussed, a base line increase of 5 percent off of the base line 1993 or 1994 year without taking into account population growth.

Ms. ROWLAND. The per person amount would probably increase but it would not increase sufficiently to purchase the same package of services as had been purchased in a previous year.

Mr. DEUTSCH. And could you try to be more specific——

Ms. ROWLAND. Because there is inflation——

Mr. DEUTSCH. [continuing] on what the increase would be? Increase of .01 percent?

Ms. ROWLAND. It is recommended now, I think, that it would be an increase of 4 percent instead of 7 percent over time.

Mr. DEUTSCH. Okay, 4 percent though, the 4 percent number is taking effect of the absolute 5 percent increase.

Ms. ROWLAND. Right.

Mr. DEUTSCH. That is not discounting for growth at all or age of Medicaid population.

Ms. ROWLAND. If there is any growth in the population, if there is inflation in medical spending so that it costs more to purchase the same package of medical services next year as it did last year, then these things would all eat into the growth rate.

Under the proposal here, most States cannot have any greater growth than inflation and even with that they would have to begin to drop beneficiaries from the program.

Mr. DEUTSCH. Right. I am just trying to talk about all the factors that we have had and, again, I thank Congressman Bilirakis because this actually is the sixth hearing that we have had just on Medicaid, so we are almost at the point that everything that has been said has been said but maybe not by everyone who has said it.

But the question, I guess, is in a State like Florida where we don't just have growth but we have growth of certain age of population. When you start taking that into a factor, what does that do in terms of, you know, your cost per patient?

Ms. ROWLAND. Well, clearly, if you have increased numbers of elderly people with greater expenses, then they are going to eat more into your ability to provide the same range of services as you did in the previous year.

Mr. DEUTSCH. And let me kind of follow up also just in terms of this inflation issue, which I think is something that I actually believe is one of the fatal flaws of my colleagues on the other side of the aisle in terms of how they are approaching health care cost containment. If we are taking the Federal Government essentially out of cost containment issues, which, in a sense, is really what the essence of both the Medicaid and Medicare proposals are, if you were projecting inflation increases over the next 5 or 10 years in general in health care, where would you put those? I mean, even though, again, we have seen anecdotal evidence and clearly there are health care plans which have reduced if not eliminated or even reduced their price, and in general we have seen some slide in terms of the increase above the rate of inflation, not very much but we definitely have seen a good direction, but overall we still see this 4.97 percent type numbers.

I guess the perspective that I have, which I think is important for everyone to at least internalize and talk to health care economists about is the fact that if the Federal Government isn't out there with a big stick as the only purchaser who can implement things like DRG's and is the actual purchaser and is worried about the cost, I mean what would your projection be on the 5- and 10-year line in terms of health care cost increases?

Ms. ROWLAND. The current projections are about 10 percent growth in Medicaid every year over the next 7 years. What the proposals being considered do is cut that growth rate in half.

What that would mean is that given increases in population, especially population in poverty, and given increased coverage of all children under the poverty level, Medicaid was expected to grow from about 36 million people covered today to about 45 million people covered in the year 2002. Under the reduced growth rate in the congressional proposals, that number would go to about 40 million, so we would lose about 5.5 to 6.5 million people if States were able to hold their spending to the rate of inflation.

If they needed a little more growth, as has been true in Medicare expenditures for all programs to say 1.9 percent, it would mean a reduction in coverage of almost 10 million people from the program.

Mr. DEUTSCH. Thank you.

Mr. STEARNS. I thank my colleague.

Let me, just before we let you go, let me finish up.

I think just in conclusion I would like to focus on your statement that the per person benefits will increase with the proposed 5 percent provided for the States in block granting. I would point out that on a hearing last week, Virginia's Health and Human Resources secretary, Kay James, told us how Virginia would respond if Medicaid were converted into block grants. She did not paint the scenario that you indicated that at a growth of 10 percent a year and, of course, at 10 percent a year, everything doubles in 7 years.

She said that Virginia would not only provide top quality medical assistance to the eligible population but would work hard to reduce the size of the population by helping them to achieve economic independence. I think we have a difference of opinion from what you are saying. In fact, several Governors today have been successful in providing more benefits, in providing cost containment and in general did not see this continued projection that you make over 10 years of 10 percent.

So I think we should, for the record, realize that a lot of Governors have been successful at block granting and, indeed, even under your own estimation that the per benefits per person will increase.

So I thank this panel for their participation and now we will have the second panel.

Jennifer Howse, the president of the March of Dimes Birth Defects Foundation; Dr. George Comerci, president, American Academy of Pediatrics, Ms. Beth Houghton, general counsel, chief information officer, the National Association of Children's Hospitals and Yvette Elkins of Columbus, Ohio.

I want to welcome all of the panelists here.

Good morning. Good morning.

Ms. Elkins, would you like to start with a 5-minute opening statement? Okay. There we go.

We welcome your daughter, I presume.

Ms. ELKINS. This is Cindy. My other daughter back there is Shelby.

Mr. STEARNS. Okay, fine.

STATEMENTS OF YVETTE ELKINS, COLUMBUS, OHIO; GEORGE D. COMERCI, PRESIDENT, AMERICAN ACADEMY OF PEDIATRICS; JENNIFER L. HOWSE, PRESIDENT, MARCH OF DIMES BIRTH DEFECTS FOUNDATION; AND BETH HOUGHTON, CHIEF FINANCIAL OFFICER AND GENERAL COUNSEL, ALL CHILDRENS HOSPITAL, ON BEHALF OF NATIONAL ASSOCIATION OF CHILDREN'S HOSPITALS

Ms. ELKINS. Mr. Chairman and members of the committee, my name is Yvette Elkins and with me are my daughters, Cindy and Shelby. We reside in Columbus, Ohio, where I am employed by the State of Ohio.

I am here today to share my experiences with you because I have heard about the proposed block grants and huge cuts in Medicaid. The very benefits that might be eliminated help me and my daughters so sufficiently that without them I would be on welfare instead of employed and our future would be bleak and hopeless, that is so often the only one possible for welfare recipients.

I grew up in a small town in Ohio. Both of my parents worked. Growing up with my brothers and sisters, I did not realize how lucky we were. My parents raised us to believe you can do anything you set your mind to do. We never went to bed hungry or worried if we were going to have a home to live in the next day. Children should not have to worry about these things.

I got my first job at a grocery store when I was 16. After graduating from high school, I was hired by the State of Ohio, the State Highway Patrol. I eventually became a State trooper.

I worked in a professional setting and made excellent wages. I lived the American dream. I enjoyed my life. I met the man I married.

And I would hear and see stories about the homeless. I listened to conversations about how out of control the welfare system has become and also I had sympathy for the homeless and anybody who would have to depend on welfare.

I was far removed from this. It could never happen to me.

Shortly after getting married, I became pregnant. From the start, I was very sick, to the point of being hospitalized. I was unable to work full time. My husband would not keep a job and we fell behind on paying our bills.

After I had Cindy, I went back to work on the midnight shift so we could make ends meet. It was stressful and exhausting. After a few months of this, I saw no alternative but to quit my job.

I thought I could live by withdrawing my retirement contributions I had made while I searched for a less stressful and demanding job. By the time it was clear that I could not depend on my husband, I desperately wanted to save my marriage. I did not want my child to grow up in a one-parent family.

By the time my retirement funds were gone, I discovered I was pregnant. Then my husband left me. I was soon evicted from my apartment.

I found myself, the day before thanksgiving, in an old, beat-up car with no working heater, pregnant and sick with my 18-month-old baby bundled up beside me from the cold. I felt like we had absolutely no place to go.

I found out that there was a church in downtown Columbus that would put us up for 10 days so that is where my daughter and I spent our Thanksgiving holiday.

I always have been a self-sufficient, independent person. So to go from making $30,000-plus a year to losing everything and having all my worldly possessions in the back of a station wagon was something I could not believe. I had two options at this point.

No. 1, to have an abortion and get back to work or, two, to have the baby and I would not be able to work. My conscience forced me to have the baby.

With that choice, and my health, there was no option but to go on public assistance for the first time in my life. I was determined to give my kids the best I could give them. In my 9 months of pregnancy, I was at various State offices checking job postings and putting in applications. Two weeks after the birth of my child, my second child, I had my first job interview. Three months after the birth of my daughter, I was hired by a State agency.

I felt very fortunate to get this job so quickly but getting hired for the position was not the end of my troubles. The starting pay for the position was $12.01 an hour. As I sat down and figured out all my expenses, including past bills, medical bills, child care and rent, I was overwhelmed. I moved forward with only faith and determination. I called the Department of Human Services on the off chance that I would qualify for some kind of assistance. I was told that I did qualify for the 12-month transitional benefits which included child care and Medicaid.

I could not put into words the relief I felt when I heard this. Without these transitional benefits, I could not even have begun supporting myself and my daughters.

In the year that I was on transitional benefits, my youngest daughter had repeated ear infections, a common problem for young children. Without the year of Medicaid benefits, I would have had to quit my job and go back on welfare to pay for medical care. Incidentally, today, I am completely self-supporting.

It is hard to raise children alone while trying to maintain a career. I still struggle to pay bills. I am divorced and receive no child support but I do the best I can and I no longer receive any government assistance.

I believe it would be a shame if the proposed Medicaid block grants and cuts would prevent a family like mine from becoming financially independent instead of one more family locked into welfare.

Thank you.

[The prepared statement of Yvette Elkins follows:]

PREPARED STATEMENT OF YVETTE ELKINS

Mr. Chairman and members of the Committee: My name is Yvette Elkins and with me are my daughters Cindy & Shelby. We reside in Columbus, Ohio where I am employed by the State of Ohio. I am here today to share my personal experiences with you, because I have heard about the proposed block grant and huge cuts in Medicaid that have been proposed.

The very benefits that might be eliminated helped me and my daughters so significantly that without them I would be on welfare instead of employed, and our future would be the bleak and hopeless picture that is so often the only one possible for welfare recipients.

I grew up in a small Ohio town. Both of my parents worked. Growing up with my brother and sisters I did not realize how lucky we were. My parents raised us to believe you can do anything you set your mind to do. We never went to bed hungry or worried if we were going to have a home to live in the next day. Children should not have to worry about these things.

I got my first job at a grocery store when I was 16. After graduating from high school, I was hired by the State of Ohio. I worked in a professional setting and made excellent wages. I lived the American dream and enjoyed my life. I met the man I married. I would hear or see stories about the homeless or listen to conversations about how out of control the welfare system has become. Although I had sympathy for the homeless and anybody who would have to depend on welfare, I was far removed from this. It could never happen to me.

Shortly after getting married I became pregnant. From the start I was very sick, to the point of being hospitalized. I was unable to work full-time. My husband would not keep a job and we fell behind on paying bills. After I had Cindy I went back to work on the night shift so we could make ends meet. It was stressful and exhausting. After a few months of this I saw no alternative but to quit my job. I thought I could live by withdrawing retirement contributions I had made while I searched for a less stressful and demanding job.

By this time it was clear that I could not depend on my husband. I desperately wanted to save my marriage. I did not want my child to grow up in a one-parent family. By the time my retirement funds were gone I discovered I was pregnant. Then my husband left me. I was soon evicted from my apartment. I found myself the day before Thanksgiving in an old car with no working heater; pregnant and sick; my 18 month old baby bundled up from the cold beside me. I felt like we had absolutely no place to go. Pride and embarrassment kept me from calling on family or friends. I found out that there was a church in downtown Columbus that would put us up for ten days. So that is where my daughter and I spent our Thanksgiving Holiday.

I have always been a self-sufficient, independent person, so to go from making $30,000+ a year to losing everything and having all my worldly possessions in the back of my station wagon was something I could not believe. I had two options at this point, #1, have an abortion and get back to work or #2, have the baby and not be able to work. My conscience forced me to have the baby. With that choice and my health, there was no option for me but to go on public assistance.

I was determined to give my kids the best I could give them. In my ninth month of pregnancy, I was at the various state offices checking job postings and putting in applications. Two weeks after the birth of my second child I had my first job interview. Three months after the birth of my daughter I was hired by a state agency.

I felt very fortunate to get this job so quickly. But getting hired for the position was not the end of my troubles. The starting pay for the position was $12.01 an hour. As I sat down and figured out all my expenses, including past bills, medical bills, child care, and rent, I was overwhelmed. I moved forward with only faith and determination. I called the Department of Human Services on the off chance that I would qualify for some kind of assistance. I was told that I did qualify for 12 months of transitional benefits, child care assistance and Medicaid.

I cannot put into words, the relief I felt when I heard this. Without those transitional benefits I could not even have begun supporting myself and my daughters. I truly believe I might have become one of those hopeless women I met in the shelter.

In the year that I had transitional benefits, my youngest daughter had repeated ear infections, a common problem for young children. Without that year of Medicaid benefits I would have had to quit my job to go back on welfare to pay for medical care. Instead, today I am completely self supporting.

It is hard to raise children alone while trying to maintain a career. I still struggle to pay bills. I am divorced and receive no child support, but I do the best I can, and I no longer receive any government assistance. I believe it would be a shame if the proposed Medicaid block grant and cuts would prevent a family like mine from becoming financially independent, instead of one more family locked into welfare.

Mr. STEARNS. Thank you.

Dr. Comerci.

STATEMENT OF GEORGE D. COMERCI

Mr. COMERCI. Thank you.

Mr. Chairman, members of the committee, I am Dr. George Comerci, president of the American Academy of Pediatrics. I am here today representing its over 48,000 physician members. I am also here as a pediatrician with 34 years of clinical experience as a medical school faculty member and also as a private practicing pediatrician.

In that time, I have seen significant progress in children's health care services in this country, including the creation of Medicaid. But I recognize that we still have a long way to go.

I want to thank you for inviting me to address this important meeting to discuss the issue of Medicaid and its importance to our Nation's children. I also am pleased to be able to follow Ms. Elkins's presentation. I think it puts my presentation in proper perspective.

As health care providers who specialize in children's health care, pediatricians know from first-hand experience the critical difference Medicaid has made in the health and access to care of children who would otherwise be uninsured. Ensuring that children are protected in any Medicaid restructuring is an investment, not a cost. The fact is, the health care needs of these children will still exist and have to be addressed, even if Medicaid no longer provides them the coverage they so desperately need.

It is essential to recognize the enormous importance of this program to the health of our Nation's children. The number of children receiving Medicaid, the national safety net on which our children depend, increased by more than 50 percent, almost 57 percent, over the last 5 years. There is no reason to expect that these trends caused by expanded eligibility to Medicaid during the 1980's but, more important, caused by decreasing dependent coverage by employers and an increase in the proportion of families with low incomes, there is no reason to think that this trend will reverse soon.

Unfortunately, the congressional funding levels for proposed Medicaid State block grants will not match the medical needs of future low-income children, particularly given current demographic trends. The American Academy of Pediatrics believes that congressional goals to restructure Medicaid can be accomplished without sacrificing the quality of the Medicaid program for children and adolescents if the following core principles are honored.

One, low-income children and adolescents must maintain Medicaid coverage.

Two, the medically necessary care ensured by Medicaid through its early and periodic screening diagnostic treatment component must not be compromised.

And, three, children and adolescents must retain access to appropriately educated, trained and certified providers of pediatric and pediatric subspecialty care.

It is important to note that 12 other pediatric provider groups support these core principles as well and have signed on to a statement urging congressional support for them.

While we recognize Medicaid's weaknesses, and there are many, the American Academy of Pediatrics opposes congressional efforts to legislate unrestricted Medicaid block grants for the States. Such unrestricted block grants threaten the funding, eligibility and bene-

fits of the program upon which millions of our Nation's children depend. There are alternatives.

The Academy believes that Federal spending can be controlled and State flexibility increased without abandoning the health care needs of low-income pregnant women and children. For example, the Academy supports congressional efforts to provide States greater flexibility to move their Medicaid populations more easily into managed care while establishing quality standards for Medicaid managed care plans.

A reasonable per capita cap that protects children's benefits and access an alternative to the unrestricted block grant is one other possibility.

Regardless of how Medicaid is restructured, minimum national standards must be preserved concerning children and pregnant women's eligibility, benefits and access to appropriate care. The following protections are needed.

First, the State maintenance of effort clause requiring both the use of the same eligibility criteria in place as of January 1, 1995, and the same level of State funding budgeted on that date.

Next, future State Medicaid funding levels must be increased through a formula which takes into account increases in the cost of medical care.

Next, States should have access to a federally funded, so-called rainy day fund or similar mechanism to prevent States from having to reduce the Medicaid program during periods of increased eligibility in the population due to a number of factors such as economic downturns that happen when it is needed most.

Accountability and entitlement to preventive care and expanded services must remain and, finally, the Vaccines for Children Program must be maintained as a separate entity, separate from Medicaid at the Federal level.

We urge Congress to focus on the impact any change in Medicaid will have on children and pregnant women. Children are not little adults; they need special care. Until all children and adolescents are guaranteed universal access and coverage, we must work to keep the few services they currently receive intact.

Thank you very much.

[The prepared statement of George D. Comerci follows:]

PREPARED STATEMENT OF GEORGE D. COMERCI, MD, PRESIDENT, AMERICAN ACADEMY OF PEDIATRICS.

Mr. Chairman, members of the Committee, I am George Comerci, M.D., President of the American Academy of Pediatrics. I am here today representing over 48,000 physician members who are dedicated to the health, safety and well-being of infants, children, adolescents and young adults. I am also here as a practicing pediatrician with 34 years of clinical experience. In that time, I have seen some progress in children's health care services, including the creation of Medicaid, but recognize that we still have a long road to travel. Thank you for inviting me to address the important issue of Medicaid and its importance to our nation's children.

The American Academy of Pediatrics couldn't agree more with Congress that Medicaid needs to be improved. The Academy reaffirms its long-term commitment to the objectives of its "Children First" proposal, which calls for the replacement of Medicaid with a one-tier, private insurance system of universal access to health care for all children through age 21 and for all pregnant women. However, until such comprehensive health care reform is implemented, we must protect the national safety net that Medicaid provides for our economically and medically vulnerable children.

As health care providers who specialize in children's health care, pediatricians know from first hand experience the critical difference Medicaid has made in the health and access to care of children who otherwise would be uninsured:

- Nearly 18 million children received Medicaid benefits in 1993;
- Without Medicaid, over 37% of all U.S. children would be uninsured;
- In 1993, Medicaid financed medical care for nearly one-fourth of all U.S. children under the age of 21 and more than one-third of children under age 6;
- In a very real sense, Medicaid is a children's program since 54% of all beneficiaries are under age 21. However, children's health care costs represent just 23% of total Medicaid spending. This figure includes the cost of caring for the disabled Medicaid population under the age of 21.

Ensuring that children are protected in any Medicaid restructuring is an investment, not a cost. The fact is, the health care needs of these children will still exist and have to be addressed even if Medicaid no longer provides them the coverage they so desperately need.

The American Academy of Pediatrics believes that, in any Congressional review of Medicaid, it is essential to recognize the enormous importance of the program to the health of our nation's children. Any changes to the Medicaid program must ensure that children, our most vulnerable population, are protected.

Medicaid Is The Nation's "Safety Net":

Quite simply, Medicaid is the national safety net on which our children depend. It becomes all the more important, particularly for low-wage working families, given recent social and economic trends. Expanding income eligibility levels, decreasing dependent insurance coverage by employers, and an increase in the proportion of families with low incomes have increased the number of children receiving Medicaid by more than 50 percent over a five year period. There is no reason to expect that these trends will reverse soon. Unfortunately, the Congressional funding levels for proposed Medicaid state block grants will not match future low-income children's medical needs, particularly given current demographic trends.

11.3 million children and adolescents received Medicaid services during fiscal year 1989; by 1993, that group grew to 17.6 million—a 56 percent increase. Last year alone 2.5 million children lost private health insurance; that was 5% of all privately insured children in America. Without the Medicaid program, most of these children would have had no where to turn.

Core Principles:

This year Congress is expected to act on proposals to restructure Medicaid in order to control federal spending and increase state flexibility in the use of federal funds. The American Academy of Pediatrics believes that these Congressional goals can be accomplished without sacrificing the quality of the Medicaid program for children and adolescents if the following core principles are honored: 1) Low-income children and adolescents must maintain Medicaid coverage; 2) The medically necessary care assured by Medicaid through its EPSDT (Early and Periodic Screening, Diagnosis and Treatment) component must not be compromised, and; 3) Children and adolescents must retain access to appropriately trained and certified providers of pediatric care.

It is important to note that twelve other pediatric provider groups support these core principles as well and have signed on to a statement urging Congressional support for them. (Statement is attached). Pediatricians have worked long and hard to assure care for children under Medicaid with current federal protections in place. Without federal protections attached to Medicaid, children will become ever more vulnerable.

Unrestricted Block Grants Place Children at Risk:

While we recognize Medicaid's weaknesses, the American Academy of Pediatrics opposes Congressional efforts to legislate *unrestricted* Medicaid block grants for the states—such unrestricted block grants threaten the funding, eligibility and benefits in the program upon which millions of our nation's children depend. Such proposals to end a thirty-year federal guarantee to America's low-income children and substitute it with an inadequately funded system of unrestricted block grants is simply unacceptable to pediatricians. Too many children rely upon the Medicaid program for us to abandon them. And that's exactly what unrestricted block grants will do. In fact, as you well know, under a block grant, not only will the program be underfunded but it will create an uneven burden for high growth states like Florida and Texas.

Alternatives:

The Academy believes we can control federal spending and increase state flexibility without abandoning the health care needs of low-income pregnant women and children. For example, the Academy has supported Congressional efforts to provide states greater flexibility to move their Medicaid populations into managed care, while establishing quality standards for Medicaid managed care plans. A reasonable per capita cap that protects children's benefits and access as an alternative to the unrestricted block grant is one other possibility.

If Medicaid spending is capped at the federal level with eligibility standards and a basic benefit package maintained as an alternative to or in conjunction with state block grants, a reasonable cap must be employed which allows for a pre-determined level of growth based on reasonable expectations of future costs of health care for vulnerable populations. Cost containment is essential, but should not impede access or compromise the quality of care.

Needed Protections for Any Medicaid Restructuring:

Regardless of how Medicaid is restructured, minimum national standards must be preserved concerning children and pregnant women's eligibility, benefits and access to appropriate care. The following protections are needed:

- A state maintenance of effort clause requiring both the use of the same eligibility criteria in place on January 1, 1995 and the same level of state funding budgeted on that date;
- Future state Medicaid funding levels must be increased through a formula which takes into account increases in the cost of medical care;
- States should have access to a federally funded "rainy day fund" or a similar mechanism to prevent states from having to reduce the Medicaid program during periods of increased eligibility in the population due to a number of factors, such as economic downturns, when it is most needed;
- A required percentage of the block grant monies should be set aside to support critical population and community-based health care services and systems development;
- The Academy believes that Federal and State Governments must require the adoption and monitoring of performance standards and measures to assure receipt of services by eligible children, especially where Medicaid managed care is involved;
- Accountability and entitlement to preventive care and expanded services must remain;
- Performance standards must be readily measurable and outcomes based, and;
- The Vaccines for Children Program must be maintained as a separate entity at the Federal level.

Conclusion:

We urge Congress to focus on the impact any change in Medicaid will have on children and pregnant women. Children are not little adults. They need specialized care. Until all children and adolescents are guaranteed universal access and coverage, we must fight to keep the few services they currently receive intact.

Mr. STEARNS. Thank you.

Dr. Howse.

STATEMENT OF JENNIFER L. HOWSE

Ms. HOWSE. Thank you.

My name is Dr. Jennifer Howse and I appreciate the opportunity to appear before this committee on behalf of our 103 chapters and 1 million volunteers who carry out the March of Dimes work across the country. For over 50 years, we have dedicated our resources to improving the health of America's children.

I will briefly summarize my testimony. I have submitted written testimony for the record. And we do commend the committee for giving us an opportunity to give you our advice and opinions about how to strengthen and preserve the Medicaid program.

The March of Dimes is particularly concerned that Medicaid is the Nation's largest publicly financed health insurance program serving women and children and, for millions of low-income fami-

lies who want to have healthy babies, Medicaid has been their insurance policy.

Between 1984 and 1990, a series of Medicaid improvements were enacted and I would like to describe some of the lessons learned from these expansions.

Lesson No. 1, Medicaid eligibility changes were successful in expanding covering for low-income working families. Based on requests from a group of Governors, a national standard for Medicaid eligibility was set for pregnant women and young children and by de-linking Medicaid from AFDC cash welfare benefits, it was possible for low-income, working, two-parent families to use Medicaid as a source of health insurance during pregnancy and the first year of life. As a result, by 1993, of the 4 million babies born in America, 1.4 million of those births were financed through Medicaid and 1 million of those families were working families whose babies were covered by Medicaid and 80 percent of those 1 million families had incomes below $20,000. So many young families in the workforce do use Medicaid as their health insurance for pregnancy and during the first year of life.

Lesson No. 2. While Medicaid spending has significantly increased over the last few years, care for pregnant women and children has not been the major reason for these increased costs. Medicaid payments for such services are less than 7 percent of total expenditure.

Lesson No. 3. States' administrative and benefit reforms in Medicaid were as valuable as the eligibility expansions. Virtually every State has used their flexibility to streamline and simplify Medicaid enrollment for pregnant women and, in addition, 44 States have enhanced prenatal and outreach benefits and many have shown significant reductions in low birth weight and infant mortality as a result.

Lesson No. 4. Medicaid expansions offset the losses in employer dependent coverage for pregnant women and infants and reduce hospital uncompensated care for births.

To summarize what further steps we believe must be taken, we believe the lessons learned from State initiatives of the past 6 years can be applied to streamline and strengthen the Medicaid program. At this point in the congressional debate, the March of Dimes would support Medicaid reforms that continue minimum national standards for eligibility and benefits while greatly increasing State flexibility in the use of managed care, for example, by replacing the waiver process for standards for access and quality.

Our specific recommendations are, one, maintain eligibility. We strongly recommend that an individual insurance card is the best way to promote personal responsibility, ensure access to care, and allow consumer choice that can balance a market approach to health care delivery.

Two, expedite enrollment of pregnant women. For women who qualify for Medicaid only at the time of their pregnancy, States should be required to offer an expedited eligibility process.

Three, continue automatic coverage for babies. Under current Medicaid law in most private insurance policies, babies are automatically enrolled in their parents' plan. All States should be re-

quired to automatically cover babies from birth at least to their first birthday.

Four, ensure adequate benefits. We urge Congress to maintain Federal standards for minimum benefits for pregnant women, infants and children. This would include preventive benefits for each individual and specialty care for those at high medical risk.

Five, and last, establish quality indicators and performance standards. The Medicaid HEDIS project is an important step toward improving quality assurance for beneficiaries. We recommend that States be required to measure quality and to use professional guidelines in this process. At the Federal level, work should continue on the evolving HEDIS framework.

In closing, I thank you for the opportunity to testify and urge the members of this committee to support further improvements of Medicaid. We recognize the potential of managed care and are working to help achieve it. We also know that setting national standards can make a critical difference.

We believe that geography should not be destiny and that a child born in Georgia deserves the same chance to be healthy as a child born in Pennsylvania. We look forward to working with you throughout the process to continue Medicaid's contribution to the health of children.

Thank you.

[The prepared statement of Jennifer L. Howse follows:]

PREPARED STATEMENT OF DR. JENNIFER L. HOWSE, PRESIDENT, MARCH OF DIMES BIRTH DEFECTS FOUNDATION

Mr. Chairman and Members of the Committee: On behalf of the March of Dimes Birth Defects Foundation, I want to thank you for the opportunity to appear before this committee. Through research, public education, community services, and advocacy, we're pursuing our mission to improve the health of babies by preventing birth defects and infant mortality. I speak today on behalf of the 103 chapters and more than one million volunteers who embody our efforts in communities across the country. For over 50 years, we have been a leading charitable organization and have dedicated our resources to the health of America's children.

We commend you, Mr. Chairman, for giving the Committee time to focus on Medicaid—the nation's largest publicly-financed health program serving women and children. For millions of low-income families who want to have healthy babies, Medicaid has been the key which opens the door to health care. Recent expansions have dramatically increased the importance of Medicaid as a source of maternity coverage and have rightfully been a central component of our national infant mortality reduction strategy—covering one out of three babies.[1]

Statistics indicate that, despite these recent expansions of Medicaid, over 9 million women of childbearing age have no health insurance, public or private.[2] Other estimates suggest that an additional 5 million women have some private insurance that will not cover their maternity care.[3]

Most low-income families cannot afford to pay for this care "out-of-pocket." Assuming no complications, the average cost of having a baby and basic health care during the first year of life is nearly $7,000[4]—this represents one-fifth of the average annual income of a couple in their early 20s. Low-income, working families need health insurance during their childbearing years.

Beyond these statistics lie names and faces of working families who face major challenges in obtaining health care. For example:

> When Kim and Ward Schuller were expecting their first child, Kim was not working and had no insurance. She did not receive prenatal care. Never did it cross their minds that their baby would be born prematurely, with low birthweight. Christopher had to spend 3 weeks in the neonatal intensive care unit. When Kim was pregnant with their second child, she sought Medicaid coverage. Without Medicaid, Kim would not have been able to afford prenatal care. Medicaid helped make a healthy birth possible for Kendall, their second child. But the story just doesn't end with Kendall as a

happy healthy three year old. This entire family's independence is the success. Both parents are working now and are off Medicaid. The Schullers are giving back to those who once were in their shoes. In her current job, Kim serves as a "Resource Mom" to other women and educates them about the importance of prenatal care in Tallahassee, Florida.

Lessons Learned from Recent Medicaid Expansions

Between 1984 and 1990, the Congress, the Reagan and Bush Administrations, and the states enacted a series of Medicaid improvements to make the program a better source of health insurance coverage for pregnant women and children. These changes focused on expanding eligibility, making benefits more appropriate, and expediting the enrollment process. With these improvements, Medicaid was able to serve an increasing number of working families who lost dependent coverage. In addition, some states have improved infant health, with a corresponding reduction in costs for the care of sick babies. The lessons learned from Medicaid expansions are extremely important to our future success in setting effective maternal and child health policy.

Lesson 1. Medicaid eligibility expansions have been successful in expanding coverage, especially for low-income working families.

Based on requests from a group of governors—led by governors from the Southern region where lack of coverage was a particular problem—a national standard for Medicaid eligibility was set for pregnant women and young children under age 6 (133% of the federal poverty level or $16,786 per year for a family of three)[5]. In addition, 34 states use their option to expand Medicaid eligibility for pregnant women and infants between 133% and 185% of the federal poverty level.[6] By delinking Medicaid from AFDC cash welfare benefits, policy makers made it possible for low-income, working, two-parent families to use Medicaid as a source of health insurance during pregnancy and the first year of a baby's life.

The following data document the success of this policy in reaching working families in need of insurance for maternity and infant care.[7]

- The 1.4 million infants with Medicaid coverage in 1993 represented about one out of every 3 babies born in the United States. Less than one-third received AFDC cash welfare benefits. (This 1.4 million contrasted with 900,000 in 1990).
- Nearly 1 million (966,850 or 68%) of these infants lived in families whose head of household was employed. For these families, Medicaid provided a source of health insurance to support the transition from welfare to work or provide coverage neither the employer nor employee could afford. (Figure 1)
- Among the infants with Medicaid insurance who lived in working families, 59% had a male in the household and 83% had family incomes below about $20,000.[8]

These statistics remind us that many young families in the workforce do not have private health insurance to cover the costs of having a baby and must rely on Medicaid.

Lesson 2. While Medicaid spending has significantly increased, care for pregnant women and children has not been the major reason for increased costs.

Half of the 4.8 million new Medicaid enrollees between 1988 and 1991 were pregnant women and children, but the costs of covering these groups account for only 11% of the $37 billion growth in Medicaid spending.[9] While the program is an important payer for maternity and infant services—accounting for 1 out of every 6 dollars paid for such care—the total cost for this population is low. Medicaid payments for maternity and infant care through the first year of life are less than 7% of total Medicaid expenditures.[10]

Expenditures for children are also low. Children are over half of the beneficiaries but account for less than one-quarter of expenditures in Medicaid. (Figure 2) This low financial figure includes children with disabilities. Average annual expenditures for children are only $1,065 per year, compared to $7,590 per elderly beneficiary.[11]

Lesson 3. States' administrative and benefit reforms in Medicaid were as valuable as the eligibility expansions.

Barriers to Medicaid enrollment are well documented. The evidence shows that even when eligible, women and children often find the traditional Medicaid application process difficult to negotiate. Virtually every state has used their flexibility to streamline and simplify Medicaid enrollment for pregnant women. For example, states have established expedited ("presumptive") eligibility programs (30), simplified application forms (42), or allowed mail-in forms (20).[12] The GAO and other analysts found that these efforts have been successful.[13]

In 1985, Congress gave states the option to create enhanced maternity benefit packages. As of 1994, 44 states had responded by adding care coordination (42), nu-

tritional counseling (36), risk assessment (43), health education (37), or home visiting (37). The impact of these enhancements is being measured.[14] North Carolina, as an example, has shown significant and dramatic reductions in low birthweight and infant mortality rates among women who received enhanced prenatal services.[15] Washington State,[16] Tennessee,[17] California,[18] and New York[19] have each seen some improvements in birth outcomes through use of more comprehensive prenatal care.

Lesson 4. Medicaid expansions offset the losses in employer-dependent coverage for pregnant women and infants and reduced hospital uncompensated care costs for births.

As employers and families could no longer afford the high cost of private insurance, many dropped dependent coverage of women and children. Medicaid coverage for pregnant women improved sufficiently to offset declines in employer-sponsored insurance, and the proportion of pregnant women who were uninsured dropped from 11% to 7% between 1988 and 1994.[20]

Hospitals, and the communities that support them, also benefited as more families had pregnancy and newborn coverage. In the mid-1980s, maternity and infant care were the single largest source of uncompensated care costs. This was a significant burden on hospitals and to state uncompensated care pools (where they existed). Prior to having protection under Federal law,[21] uninsured pregnant women in labor were being turned away from hospitals (who couldn't afford to absorb the cost of the birth). But even after a Federal law change, the burden remained on hospitals. Medicaid expansion was the most important financial component of the solution to this problem. As Medicaid expanded for pregnant women, the proportion of births for which hospitals experienced uncompensated care costs declined by 40% (from 13% in 1986 to 8% in 1990).[22] Uncompensated care and government-sponsored direct services (e.g., clinics) remained at 10% of hospital costs and 7% of physician services costs; however, this amount would be higher without Medicaid coverage.[23]

What Further Steps Must be Taken?

As an organization concerned about the health of children, the March of Dimes urges Congress to continue basic protections for pregnant women, infants, and children as it makes Medicaid reforms. We agree that the program can be strengthened by state actions and have cited the evidence above. The March of Dimes would support Medicaid reforms that continue minimum national standards for eligibility and services, while increasing state flexibility in the use of managed care—replacing the waiver process with standards for access and quality.

We urge you to apply these lessons learned from state initiatives to current Federal Medicaid reform proposals.

1. **Eligibility:** We strongly believe that an individual insurance card is the best way to promote personal responsibility, ensure access to care, and allow consumer choice that can balance a market approach to health care delivery. Converting Medicaid from an individual entitlement to a state entitlement program may reduce individual responsibility.
2. **Enrollment of pregnant women:** For women who qualify for Medicaid only at the time of pregnancy, the enrollment process can cause delays in receipt of prenatal care. States should be required to use an expedited eligibility process, such as the current "presumptive eligibility" process or a new approach designed for their state. Coverage for the woman also should be guaranteed from enrollment through 60 days after she gives birth.
3. **Automatic newborn coverage:** Under current Medicaid law and most private policies, babies are automatically enrolled in their families' plan. This approach can be particularly helpful to managed care organizations who take a more comprehensive approach to care and its coordination. Automatic coverage that begins at birth and continues until the first birthday should remain a requirement for states.
4. **Adequate benefits:** Medicaid now provides for prenatal care, services at the time of birth, and care for children in low-income, uninsured families. Targeted prevention benefits—such as enhanced prenatal care and regular well baby visits—have proven beneficial and cost effective. Specialty care for newborns is a life and death issue for nearly 10% of all babies.[24] The tragedy that can result from not receiving care during pregnancy and the first year of life is also well documented. Why take chances with the next generation? We urge Congress to maintain Federal standards with minimum benefits for pregnant women, infants, and children.
5. **Quality indicators and performance standards:** The Medicaid HEDIS project (an adaptation of the Health Plan Employer Data and Information Set)[25] is an

important step toward improving quality assurance for beneficiaries. However, it is a work in progress. In particular, the HEDIS draft document indicates that measuring outcomes may be difficult due to lack of continuity in enrollment, data limits related to small population size, and other factors. The March of Dimes believes that for care delivered to pregnant women and infants, measures of quality and performance should be based on nationally accepted professional standards such as the *Guidelines for Perinatal Care*[26] jointly published by the American College of Obstetricians and Gynecologists (ACOG) and the American Academy of Pediatrics (AAP). We recommend that states be required to measure quality and performance and to use professional guidelines in the process. At the Federal level, work should continue on the evolving HEDIS framework.

In closing, I want to thank you for the opportunity to testify and urge the members of this Committee to support further improvements in Medicaid. We recognize the potential of managed care and are working to help achieve it. We also know that setting national standards can make a significant difference. Geography should not be destiny. A baby in Georgia deserves the same chance for a healthy birth as one in Pennsylvania. The nation cannot reach its health objectives, including our infant mortality reduction goals, through a patchwork of coverage. The Reagan and Bush Administrations recognized this fact when they expanded the program during the 1980s. We look forward to working with you throughout this process to continue Medicaid's contribution to the health of America's children.

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[3] Gold, RB, et al. *Blessed Events and the Bottom Line: Financing Maternity Care in the United States.* Alan Guttmacher Institute, New York, 1987.

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[5] *Federal Register.* Vol. 60, No. 27, p. 772, February 9, 1995.

[6] National Governors' Association. Table 3 Annualized Medicaid Eligibility Thresholds AFDC, Medically Needy, OBRA Pregnant Women and Infants. *Issue Brief on Medicaid.* Washington, DC. February 1995.

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[22] Singh S, Gold RB, and Frost J. Impact of the Medicaid Eligibility Expansions on Coverage of Deliveries. *Family Planning Perspectives,* 26:31-33, 1994.

[23] Committee on Perinatal Health. *Toward Improving the Outcome of Pregnancy*. March of Dimes Birth Defects Foundation, White Plains, NY. 1993. See RAND analysis, p. 59 and Appendix 10.

[24] Data from the U.S. Centers for Disease Control and Prevention indicate that for 1992, 10-11% of all infants are born premature (prior to 37 completed weeks gestation), 7% are born at low birthweight (less than 5.5 pounds), 5-7% have a serious congenital anomaly, and 1.5% have an Apgar test score indicating extreme risk at 5 minutes after birth. These categories overlap in some cases but point to the level of risk faced by at least 10% of all newborns. Most of these circumstances require the services provided in a neonatal intensive care unit (NICU).

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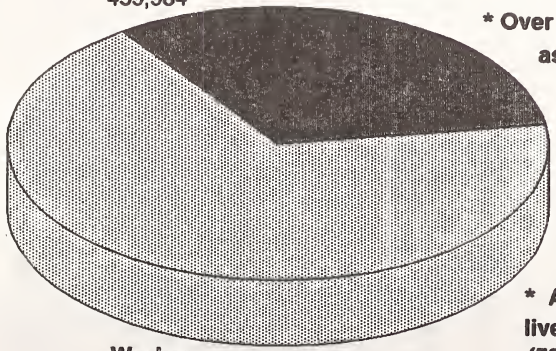
Figure 1

Infants with Medicaid Coverage
By Characteristics of Their Families, U.S. 1993
- Work Status for Head of Household -



* Over 1.4 million infants had Medicaid as a source of health insurance.

* Nearly 1 million (68%) of these infants lived in families whose head of household was working.

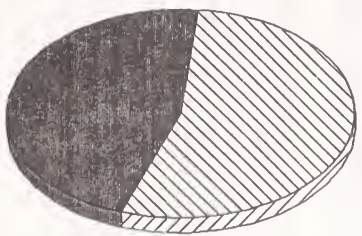
* Among babies insured by Medicaid who lived in a working family, 574,000 (59%) had a male head of household.

Source: Employee Benefit Research Institute
Based on March 1994 Current Population Survey
Figure prepared by March of Dimes

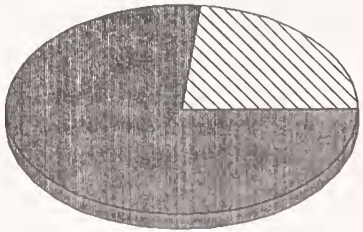
Figure 2

Children's Share of Medicaid

Beneficiaries and Expenditures, U.S., 1993



54% of beneficiaries



23% of expenditures

Note: Children's totals include all children under age 21, including AFDC, poverty-related, and disability categories of eligibles.
Source: HCFA data published by MCH Coalition. Chart by March of Dimes.

July 1995

Mr. STEARNS. Thank you, Dr. Howse.
Ms. Beth Houghton.

STATEMENT OF BETH HOUGHTON

Ms. HOUGHTON. Thank you.

I am Beth Houghton, chief financial officer and general counsel of All Children's Hospital in St. Petersburg, Florida. Dennis Sexton, president of our hospital and chairman of the National Association of Children's Hospitals is unable to be here today.

Today, I am here to talk about being accountable and responsible for the health of our Nation's children. Those of us who care about the children we serve strongly appreciate the need to control Federal spending and to increase State flexibility in administering the Medicaid program but we believe such effort should be accompanied by clear national standards for children's health coverage, access to medically necessary care and access to children's health care specialists.

Children's hospitals are regional and national centers of pediatric care serving a large population of families whose children come to us from long distances because of their extraordinary needs. For example, half of our hospital's patients come from outside of our immediate county. We have treated children from all 50 States.

Medicaid is a critical source of payment for the children and the families children's hospitals serve. On average, Medicaid pays for nearly half of the inpatient care provided by a children's hospital. In fact, Medicaid pays for 60 percent of the inpatient care provided by our hospital.

Reducing the growth in projected Medicaid spending could have a major impact on our ability to care for these families. The National Association of Children's Hospitals estimates that proposed Medicaid savings could translate into the equivalent of about 2 years' worth of a children's hospital's current annual Medicaid income, if the savings were allocated proportionally among all providers.

However, these estimates are probably conservative. Managed care is the best tool States have to improve efficiency in health care but it is largely untested for long-term care and for services to the disabled and elderly which account for 70 percent of Medicaid spending. That will only increase the pressure on States to try to achieve more savings from coverage for children.

These estimates are also conservative because they don't take into account the potential elimination of disproportionate share of hospital payments which are especially important to children's hospitals. For my hospital, disproportionate share payments account for 10 percent of our Medicaid payments.

We believe targeting some amount of disproportionate share payments to hospital with a truly significant percentage of Medicaid and uncompensated patients is essential.

Mr. Chairman, I would like to offer four recommendations for ensuring accountability for children's health care under a restructured Medicaid program. First, we believe accountability standards are needed to ensure current eligibility for low-income children will not decline. Children are the fastest growing segment of the unin-

sured population. Medicaid is the only program standing in the way of millions more becoming uninsured.

Second, we recommend that there should be accountability standards for demonstrating that children assisted by Medicaid will have access to medically necessary care. For example, children requiring medically necessary hospital care should not be forced to leave the hospital because of arbitrary limits on days of hospitalization.

Third, we recommend that all States should be accountable for children's access to pediatric specialty care, just as we are currently trying to do in Florida. But we need national standards, not just State standards, because children are so much more likely than adults to have to cross State lines to get the pediatric specialty care that they need.

And fourth, we recommend that children with chronic health conditions should receive special consideration and protections in restructuring Medicaid. Children with chronic health conditions should not be enrolled in Medicaid managed care unless their families choose such a plan. Because the numbers of these children are so small, their needs will be lost without special attention.

Mr. Chairman, in closing, I would like to conclude with one critical message. While restructuring Medicaid, we need to produce a system that is accountable for children's eligibility for health care coverage, ensures that low-income children receive medically necessary care, and provides access to pediatric specialists. This recommendation is endorsed by more than 150 maternal and child health organizations as well as pediatric health leaders throughout the country.

Thank you.

[The prepared statement of J. Dennis Sexton was received for the record:]

PREPARED STATEMENT OF J. DENNIS SEXTON, CHAIRMAN, BOARD OF TRUSTEES, THE NATIONAL ASSOCIATION OF CHILDREN'S HOSPITALS

I want to thank you, Mr. Chairman, and the rest of the members of the subcommittee for giving me the opportunity to testify before you today.

Mr. Chairman, as President and Chief Executive Officer of All Children's Hospital in St. Petersburg, Florida, and Chairman of the Board of Trustees for the National Association of Children's Hospitals (N.A.C.H.), I am devoted to the health care needs of children.

Today, I am here to talk about being accountable and responsible for the health of our nation's children. Those of us who care about the mission of children's hospitals and the children we serve, strongly appreciate the need for efforts to control federal spending and to increase state flexibility in administering the Medicaid program. But we also believe such efforts should be accompanied by clear and consistent national accountability standards for children's health coverage, their access to medically necessary care, and their access to children's health care specialists.

Children's hospitals are regional and national centers of pediatric care. All Children's Hospital has 168 beds, 1800 employees, and 300 physicians to meet the complex health care problems of children. Currently, 55 percent of our patients are from outside the county. Furthermore, we have treated children from all 50 states and 36 nations. As you can tell from these figures, we are by no means simply a local hospital. We are a regional hospital that serves a large population of families and children who come long distances to us because of their extraordinary needs.

All Children's Hospital is able to stay ahead of the curve in providing care ever more cost effectively because we focus first on the needs of children and their families. For instance, All Children's Hospital recently opened an outpatient clinic in New Port Richey, north of St. Petersburg. By giving families access to specialized care for their children in our outpatient clinic closer to their homes, we enable them to avoid the personal and financial expense of traveling longer distances for inpa-

tient care at our regional tertiary care facilities, except when it is truly necessary. It is more cost effective for the families, the hospital and the insurer.

Our state has also been ahead of the curve. For years, the State of Florida has had standards to protect access to appropriate care for children with special needs and children who rely on Medicaid. Florida has been a leader in setting accountability standards for how we serve children. I am proud that All Children's Hospital consistently meets those standards.

Even though the population of children we see is diverse in every respect, one common characteristic of those children is that they are sick—often, very sick. In many cases, our physicians are the last hope to help improve the condition of critically ill children. When our physicians first see a child, the child is usually in our intensive care ward. Many will remain there for weeks, sometimes months.

Another common characteristic of the families and children we serve is the source of paying for their care. Medicaid is increasingly essential for helping families to meet the health care needs of their children. Nationally, Medicaid is responsible for the health care coverage of one in every four children, one in every three infants, and nearly half of the inpatient care provided by a children's hospital on average. Sixty percent of the inpatient care provided by our own hospital is covered by Medicaid.

This certainly does not mean that all of the children assisted by Medicaid whom we serve can be classified as "welfare" cases. In Florida, over fifty percent of children receiving Medicaid are from families with at least one working adult. For these families, Medicaid is a safety net, one that has enabled families to work instead of relying on welfare for their children's health care coverage, or facing financial catastrophe in the event of a seriously ill or injured child.

Because Medicaid pays for such a large percentage of care in children's hospitals, all families of children served by our hospital benefit directly or indirectly from the program. Without Medicaid, the number of privately insured children alone would not be large enough to sustain the regional pediatric specialized providers, equipment and services required by all of the sick children we serve. Without Medicaid, our hospitals could not sustain the educational programs that train many of our country's general pediatricians and most of its pediatric subspecialists.

For children's hospitals, cutting projected growth in Medicaid spending could have a significant impact on children's hospitals. N.A.C.H. estimates that Medicaid savings called for in the budget resolution could translate into the equivalent of about two years of a children's hospital's current annual Medicaid income. The savings required could be the equivalent of the costs of employing 400 people full-time or providing care to 800 inpatient children during a year. Actually, the loss of Medicaid could be even greater because N.A.C.H.'s estimates assume spending will be reduced in proportion to the current share of national Medicaid spending attributed to children's hospitals. However, children and the providers devoted to their care are likely to account for a greater share of Medicaid spending, since Medicaid managed care is largely untested for the disabled and nursing home care for the elderly.

These estimates are also conservative because they assume that disproportionate share hospital (DSH) payments to qualifying children's hospitals will continue. DSH payments represent a badly needed financial safety net for children's hospitals. Without any disproportionate share program, our Medicaid reimbursements would cover on average 16% less of our costs. We believe that it is essential that some amount of DSH payments continue to be targeted towards those hospitals with a significant percentage of Medicaid and uncompensated patients, however the Medicaid program may be restructured.

As the Committee considers ways to restructure Medicaid and to reduce the growth of the program, we ask that children's health coverage remain a top priority. There is bipartisan support for doing so. For example, Senator Kit Bond (R-MO) along with two Republican and two Democratic colleagues, sponsored an amendment to the Budget Resolution, which directs Congress to make children's health a priority in restructuring Medicaid. The Bond Amendment was unanimously endorsed by the Senate Budget Committee, and included in the final conference agreement. The amendment reminds us that we must be careful about how the Medicaid program is restructured. The goals of deficit reduction and increased state flexibility must be achieved without increasing the number of uninsured children or causing the quality of care for children assisted by Medicaid to suffer.

I would like to offer four recommendations for making sure a restructured Medicaid program is accountable for children's health care.

First, accountability standards for Medicaid should ensure that current coverage for low-income children will not decline. Children are the fastest-growing segment of the uninsured population. Currently, Medicaid is the only program standing in the way of millions more becoming uninsured. In fact, without Medicaid, 40 percent

of all children would be uninsured. The leadership of every major national organization of pediatric providers—including pediatricians, nurses, researchers, educators, and hospitals—and over 150 maternal and child health organizations join us in requesting that there be minimum eligibility standards to protect children from loss of health coverage under Medicaid.

Second, there should be accountability standards for demonstrating that children assisted by Medicaid will have access to medically necessary care. Our Medicaid costs in the State of Florida average under $1,000 per child per year, compared to over $5,000 per elderly adult. In the business world, we refer to this as a very wise investment with a high rate of return. Medically necessary care is particularly critical for children with unique health conditions and needs. For medical, ethical, and financial reasons, Congress voted to assure children have medically necessary care under Medicaid in 1989. States should remain accountable for that standard. We should not return to the days when a state could impose arbitrary limits in the hospitalization of seriously ill children.

Third, accountability standards should ensure that children have access to pediatric specialty care. Children's conditions are often much more intense in their duration because of the body's defense systems not being fully developed. When a child becomes ill, what appears to be a relatively harmless medical problem can become very critical in a short time. We know that it makes no more sense to send a seriously ill child to an adult specialist than it makes sense to send a seriously ill grandparent to a pediatrician. States should be accountable for children's access to pediatric subspecialty care, just as we are currently trying to do in Florida. But we need national standards, not just state standards, because children are so much more likely to have to cross state lines to get the pediatric specialty care they need.

Fourth, children with chronic health conditions should receive special consideration. Children's hospitals have recommended that children with chronic health conditions need not be enrolled in Medicaid managed care unless their families choose such a plan or unless it is under a specific demonstration project for managed care for this population. States have very little experience with these children in mandatory managed care. Providing this exception for at least some period of time would allow states to develop guidelines for care, system performance standards and methods of capitation and/or risk adjustment specific to this population. Because the numbers of these children are so small, their needs will be lost without such special attention, because they are so vulnerable, the consequences of such loss can be very grave.

Mr. Chairman, I am proud to have devoted my career to All Children's Hospital and honored to testify on behalf of the nation's children's hospitals. In closing, I would like to reemphasize one critical message from my testimony: While restructuring Medicaid, we need to produce a system that is accountable for children's eligibility for health care coverage as well as ensuring that low-income children receive medically necessary care and have access to pediatric specialists. Thank you.

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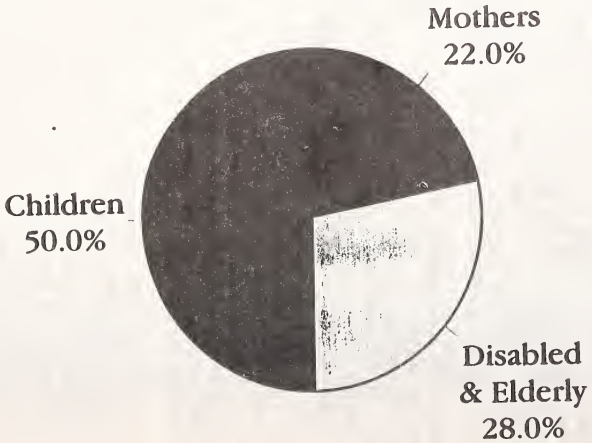
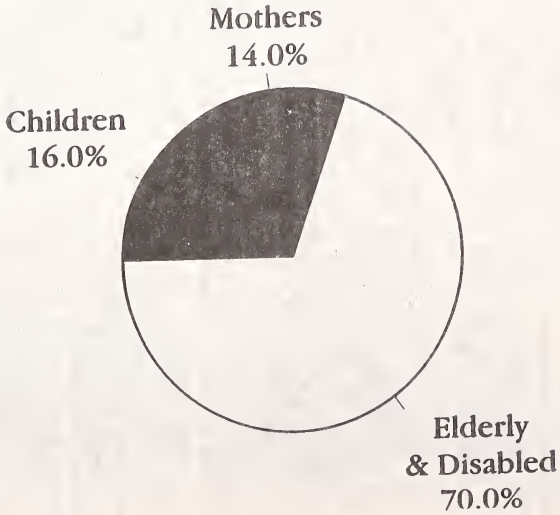
Medicaid Recipients



Medicaid Spending



Mr. STEARNS. Thank you.

Let me just open up by reiterating that Medicaid spending has been exploding, growing at an average annual rate of 19.1 percent between 1990 and 1994. During 1991, Federal Medicaid outlays grew by 27.8 percent. They grew another 29.1 percent in 1992.

With this huge amount of explosion and both the President and the Republican majority providing and promoting some type of control here, my question is for Dr. Comerci. You mentioned in your opening statement that we are abandoning Medicaid and, in fact, last week Virginia's Health and Human Resource secretary, Kay James, told us how Virginia would respond if Medicaid were converted into block grants so it could provide more coverage, and they would reduce the size of population by helping people to achieve economic independence. And I think Ms. Beth Houghton is representing the folks at the National Association of Children's Hospitals and I think Dennis Sexton, the president and CEO there, has indicated that they can enhance the Medicaid program administrative flexibility while increasing Medicare spending.

So I think, let me open with you, Ms. Houghton, can you back up your statement or the statement that Mr. Sexton was providing us, that in fact, Medicaid's program administrative flexibility, while increasing Medicare spending, will in the long run enhance service, delivery, efficiencies achieved by States and localities?

Ms. HOUGHTON. We do believe there are opportunities to improve the actual delivery of care within our State and that more State flexibility in particular with regard to managed care could not only save us money going forward but could enhance care if done properly and with appropriate standards.

But key to that is that we don't abandon those core values that I talked about in my testimony. And that is assuring that children who are currently eligible remain eligible, the coverage to services is appropriate given medical direction administration that we don't abandon the access that kids covered by Medicaid have historically had to appropriate pediatric specialists.

If those values are adhered to and those standards remain constant then, yes, degree of flexibility in the way that States operate their Medicaid plans we believe could bear fruit for all of us.

Mr. STEARNS. There has been some talk about some exciting innovations that could be provided with block granting and providing this flexibility for the States, including prenatal immunization, nutritional outreach services.

Do you perhaps want to talk a little bit more about that?

Ms. HOUGHTON. There are a number of innovations and children's hospitals across the country have historically provided innovative programs, even when no one provided financial incentive to us to do so and sort of before it was fashionable. So there are great opportunities and we are, as front line providers in care for children, as are the pediatricians of this country, very much interested in innovative models of care. Those can be provided currently, those can be provided with the incentives that managed care provides.

One does not require changing the entire funding mechanism to the States for their Medicaid program to encourage those kind of innovations in care.

Mr. STEARNS. That's a question I have.

I will yield to the gentleman from California, Mr. Waxman.

Mr. WAXMAN. Thank you very much, Mr. Chairman.

Ms. Elkins, I want to thank you very much for being here today. I think it is important for us to hear from somebody who has had an experience with the Medicaid program and how important it is and I just wanted to thank you so much.

Ms. ELKINS. Thank you.

Mr. WAXMAN. For the other panelists who are involved in a more day-to-day type of activity in giving care, the Medicaid program requires States to do certain things in order to receive certain funds and in order for them to get Federal funds to pay for nursing home and long-term care, they must agree to cover basic health services to all poor children up to 11½ years old and over the next 7 years we are going to increase that up to 18.

Our current Medicaid law also has some requirements that payments to institutions and practitioners that deliver care to children are protected, that States have to pay a reasonable and adequate rate. And for physicians, they have to pay a rate sufficient to ensure adequate participation.

Now, if we move to a block grant, the States will be given flexibility and these coverage requirements and payment protections are all going to be repealed. The Republicans would also cut the matching funds to assist the States in meeting the health and long-term care needs of their uninsured population by $182 billion or 18 percent over the next 7 years.

Let me ask first of all to Dr. Comerci or Ms. Houghton, how do you think the States will respond? Will they freeze or cut payments to pediatricians and children's hospitals or will they have managed care plans do this for them? Will they reduce coverage of children by dropping their eligibility standards to below the poverty level? And if they don't do either of these, whose coverage will they terminate and whose payment rates will they freeze or cut?

Ms. HOUGHTON. I think they will do all of those things and we have seen each and every one of those in the State of Florida at one time or another. Currently, payments to pediatric subspecialists have been cut 30 percent over the last 30 years in large part in response to the need to balance the State budget.

It was not so many years ago, 8 or 9 years ago, when many of the children we care for today were not eligible for Medicaid at all in the State of Florida and we saw what that meant. It meant that there were not adequate numbers of neonatal level three beds throughout the State and there were midnight calls to try to find such a bed open and available for children within the State.

So a variety of implications will, in fact, occur from the State level on down to the providers. Payments will no doubt be reduced, eligibility will no doubt be reduced and coverage for certain services may not be in existence or may be arbitrarily limited.

All of those will have the impact of denying care to children for the services that they require.

Mr. WAXMAN. Dr. Comerci.

Mr. COMERCI. As I was getting ready to respond, I was thinking of the old medical school answer to the multiple choice question and that is, "all of the above." And I think the problem is that the

needs of children, health care needs of children, are not going to go away; they are going to be shifted somewhere. And I think that is one of the fallacies, is that we think that because we don't fund it, the needs are going to disappear. But those youngsters are going to appear at emergency rooms, getting care that often is much more expensive and also sometimes inappropriate because it is done in an emergency situation.

I think many pediatricians, in fact, the pediatricians who are doing the most in terms of the highest percentage of Medicaid patients in their practice are the ones that are apt to suffer the most. Because many of the pediatricians tell me as I move around the country that they are being reimbursed just about at their overhead or in some cases below. That is okay when you have 3, 4 percent of your practice as Medicaid patients. But where some of the most dedicated pediatricians have 35, 40 percent, you can't continue to run a practice.

So I think pediatricians will have their reimbursement cut as would other physicians and I think that the services will be decreased, possibly the numbers of children who now are eligible will be cut and they will no longer be eligible when the States can make their own rules.

Children really are at a major disadvantage when they have to compete with other segments of society. Historically, we know this. They don't vote, they are very vulnerable. And I think they will come out as the losers when they have to compete with other segments of society at a State level.

Mr. WAXMAN. Thank you very much.

Mr. BILBRAY [presiding]. Thank you.

Dr. Comerci, you were talking about those segments of society that tend to be gaining resources that maybe we need to use for these needy children. Especially in your profession, what does your malpractice insurance cost you a year?

Mr. COMERCI. My premiums are about $12,000 a year and pediatricians are lucky because they are one of the lowest in the premiums.

Mr. BILBRAY. What State do you practice in again?

Mr. COMERCI. Arizona.

Mr. BILBRAY. Okay.

I am sure you will find that the more you are involved with delivery of poor women, the higher the percentages of malpractice insurance go up. When I was a San Diego County supervisor, we provided those services to the poor and needy. The perinatal services we provided included 30 to 40 percent of the cost, being eaten up by malpractice insurance, because the liability of that population was so huge. When we start talking about who is getting the money here, we talk about the huge overhead to provide base line services. This is basically draining off huge amounts of resources and when I was faced with the fact that I could increase 30 to 40 percent more services to needy women, if I could just get the legal profession off the doctor's back long enough. In addition, the level of tort risk for those who serve the poor is disproportionately much higher because of the complications.

When we start talking about these issues, let's get back to the fact of what is driving up this price tag.

Doctor, your comment about the child immunization program was quite interesting to me because while I was Chairman of the San Diego County Board of Supervisors, we initiated the original pilot program for child immunization under the previous administration's guidance. This was a great success when we administered the program in San Diego county with a small, intimate group of 2.6 million people.

Now that it has gone nationally, my people are telling me it is an absolute nightmare. The concept of having a huge warehouse with centralized distributing in New Jersey, does not seem very close and intimate to our working class parents in San Diego.

Do you believe that we can make our system more efficient by giving the flexibility, at least more flexibility to the local agencies so they can provide the good programs and give that flexibility?

Mr. COMERCI. I think the vaccine for children program was in a state of evolution and, as you know, that warehouse concept was discontinued. But I think each State should enjoy flexibility in this vaccine for children program. They ought to have the opportunity to have universal vaccines, to be able to purchase vaccines at a very low cost and provide them to uninsured or to Medicaid patients.

Mr. BILBRAY. But you do agree that the warehouse has really become the symbol of what not to do, central command and control, Federal Government trying to distribute everything from a centralized——

Mr. COMERCI. I think that is absolutely so and I think it is possible for that program to be administered and operated on a State basis and I think that is where we have seen it to be most successful.

Mr. BILBRAY. Yes. I mean, it was very, very successful when we kept to that level.

I am glad to hear that you support granting States greater flexibility for the administration and I think that this one program is probably an example of the do's and dont's of the strategies.

The managed care experts say that we need the flexibility for service delivery and outcome. What innovations do you see that we need to do today to make it possible tomorrow to have greater State flexibility? Where do you see the line? You want a minimum standard that we say, this is where we have to provide it? And does it allow the States to then figure out how to provide those standards rather than the command and control we had before?

Mr. COMERCI. The flexibility ought to include the opportunity to try new experiments, for instance, be able to obtain a waiver for putting your Medicaid patients into managed care without having to jump through hoops. And I think Senator John Chaffe has introduced a bill in the Senate that we would be in favor of where it would make it much easier to move your Medicaid population into managed care.

I think managed care in itself is not the savior of medical care in this country. There is good managed care and there is poor managed care and I think one of the things that the States would have to do is make sure that they evaluate each program very carefully before they contract with managed care companies.

Arizona, for instance, has enjoyed the opportunity to have their Medicaid population in a managed care system and it has worked fairly well with definite exceptions. But we were very careful about who we contracted with in terms of who was going to provide that care.

So the flexibility to pick the kind of delivery system that is appropriate for your State, I think flexibility in terms of what populations will be covered, what the eligibility requirements within reason would be would be areas where the States could exercise some choice in how they want to run——

Mr. BILBRAY. What is the population of managed care in Arizona?

Mr. COMERCI. In Arizona, I can't give you that figure off the top of my head and I——

Mr. BILBRAY. I will tell you, in California by the end of the year, we hope to have over 5 million. San Diego has been a real leader in that and there we talk about a cost of living that is huge but the cost of service has been brought down severely.

I do want to say, though, that we have to be quite open. Providing these programs in San Diego is totally different than providing them in Mississippi. And we need to recognize that. We want to have certain standards but we also have to remember there is a very, very diverse Nation out there. As somebody who grew up on the West Coast and then come back here, the cultural, social and economic differences are extraordinary and we barely speak the same language in my opinion.

But I think that it is a real challenge to try to make sure we cover these bases and continue these services.

The gentleman from Florida.

Mr. DEUTSCH. Thank you, Mr. Chairman.

Ms. Houghton, I am sure that you are aware that Governor Chiles has testified in front of this committee and specifically talked about the proposed cuts, the $184 billion number would have in terms of Florida. In addition, the Governor has recently sent a letter to this committee elaborating the point. I will quote:

"The Republican plan would devastate Florida's Medicaid program. The loss of at least $8.1 billion in Federal funds would necessitate deep cuts in State programs by the legislature. Florida already provides fewer coverages and pays its providers less than most Medicaid programs. The Republican proposal would force even greater reductions in coverage and services."

Since the Governor is conceding that Florida already pays its providers less, what do you think in particular, from your facility's perspective, would happen with the $8.1 billion cut in Florida?

Ms. HOUGHTON. It is difficult over time to predict exactly which services would be lost but it is clear from our history that when Medicaid expansions occurred, we were able to do things that, were they removed, we would not be able to do. We were able to open 15 more neonatal beds on top of the 25 beds that had been in existence.

That decision literally had to wait until Medicaid eligibility and funding was such that we thought that we could continue in a financially viable way as a hospital and support those additional beds.

As funding decreased or funding for that same body of children decreased over time, we may have to reverse some of those decisions to expand either services or geography. As a children's hospital and, not unusually, as a children's hospital, we provide care for children for a great region, for 14 or 15 counties across the west coast of Florida. We routinely on a daily basis receive requests to transfer children in, children who are critically ill who have no other source of appropriate care in their own communities.

Over time, if our funding did not allow, our geography, that area we are able to keep an open door policy for, would no doubt have to contract so I think the scope of services would clearly contract, those highly technical services like transplant care for children from further away from our home base, community education programs for which we are not paid anything but benefit the entire community and medical education would be some of the first we would have to look at to reduce if our payments for the children who still come to our doors was reduced.

Mr. DEUTSCH. I guess I am trying to just, as one facility, sort of the end or close to the end of the food chain of the billion, $8 billion in cuts, maybe if you talk about the services that you provide in terms of expansion, you can be clearer besides the neonatal beds.

What do you do now that you didn't do 5 years ago, let's say.

Ms. HOUGHTON. We provide a variety of transplant services today, for instance, that we did not provide 10 years ago before the Medicaid expansions occurred in Florida.

Mr. DEUTSCH. And what would happen to those children if they did not get transplants?

Ms. HOUGHTON. If those children were accepted by another transplant center, they might receive that transplant, but that is often not the case, that a transplant center out of State, for instance, is willing to accept a medically indigent child for a transplant without adequate payment. So there could be children who are not accepted by any program to receive a needed transplant.

There were children requiring neonatal level three services who literally phone calls were going on in the middle of the night to try to find an empty bed. The regional perinatal program which is the way the State of Florida did provide for level three centers, primarily up until 9 or 10 years ago, each one of those centers was full virtually all of the time. Only those centers that, in essence, did not provide access to Medicaid patients had beds available.

Mr. DEUTSCH. I am not familiar with in Pinellas County how your hospital district is set up. I am pretty familiar in Broward and Dade and Monroe Counties but one of the sort of, again, questions that I have about this whole approach is if in fact in Florida we are going to cut the number of recipients, someone who has a heart attack, someone who needs major surgery of some sort who is not covered by private health insurance, not eligible for Medicaid is still going to go to a community hospital and still be provided with the service although, again, without any kind of network of physicians before they get to the emergency room.

In your community, in Pinellas County, what would happen under this proposal, particularly in a State like Florida. I see no way that the absolute numbers of beneficiaries under Medicare would not go down relatively dramatically. I mean, the Governors

talked about 300,000 people. How would that affect Pinellas County and your facility?

Ms. HOUGHTON. Those children are still there, they still have the same health care needs and, to the extent our facility was able to do so, we would continue to attempt to meet those needs. But Dr. Comerci referred to it earlier. It often has subtle but very real impact on the entire continuum of care.

Yes, a child with an emergency presenting at emergency room would still be cared for but that is probably not the most appropriate venue and that child should have been provided appropriate preventive care from the beginning of life. That is the kind of care that is also likely to just not exist for those children who are currently eligible for Medicaid but might, in the future, not be eligible for Medicaid. That is a poor way to cut money in the long term but probably the most likely way we would see impact on children. Those who don't receive relatively cheap preventive services in the early years of life.

Mr. BILBRAY. The Chair would thank you very much, panel. We appreciate it.

The Chair would like to poll those members who are present if we want to break for lunch for 60 minutes or an hour, whatever comes first. Okay, then, let's take the next panel. I don't want to get the mothers mad.

[Brief pause.]

Mr. BILBRAY. I apologize to the panel. I am going to have to excuse myself for a few moments and Dr. Coburn will take care of the——

Mr. COBURN [presiding]. I thank you all very much for being here. I am sorry that we are playing rotary chairs.

By method of introduction, we have the following, if I may introduce them.

Mr. Gail Warden, President and CEO, Henry Ford Health Systems, thank you. Mr. Edwin Brown, Florida Community Health Centers. And then—and please help me with this name, Brendy Hantzes, Brendy, thank you for being here and then Mark Barnes, I know Mark, glad you're here.

Ms. Hantzes, would you like to start?

Ms. HANTZES. Sure, I'll go first.

STATEMENTS OF BRENDY HANTZES, WASHINGTON, DC.; CHRIS KOYANAGI, CODIRECTOR FOR GOVERNMENT RELATIONS, BAZELON CENTER FOR MENTAL HEALTH LAW; MARK BARNES, EXECUTIVE DIRECTOR, AIDS ACTION COUNCIL; GAIL WARDEN, PRESIDENT, HENRY FORD HEALTH SYSTEM; AND EDWIN W. BROWN, CHIEF EXECUTIVE OFFICER, FLORIDA COMMUNITY HEALTH CENTERS, INC.

Ms. HANTZES. First, I would like to thank you for the opportunity to come and speak to you here today concerning my daughter, Molly, the block granting of Medicaid and specifically the home and community-based waiver program that has enabled our family to survive despite the trying circumstances of caring for our profoundly disabled daughter.

Please do not go forward with your proposals to block grant or cap Medicaid. I am afraid that if you do, our family will lose Molly again.

My name is Brendy Hantzes. In 1981, I graduated from college and moved to Washington, D.C., to begin work. That winter, I met my future husband and we were married 2 years later. Along came the children, one then two. We settled into a nice, suburban lifestyle.

My husband's firm was doing well, I was active as a volunteer, both in the community and at my children's preschool. Then along came child No. 3.

Molly, my long-awaited daughter, was born with lissencephaly, a devastating neural tube birth defect resulting in profound physical and mental disabilities, a seizure disorder and a very shortened lifespan, so we are told. Now, let me reintroduce myself.

We are the classic example of a family that has a child whose health and developmental needs are so great that unsupported the family breaks, and that we did. But families don't just break on contact with a child with special needs. It is a slow, painful, brutal process of isolation, loneliness and rejection by family, friends, neighbors, relatives and oftentimes even from the very people whose job it is to provide services and supports.

Almost from the first day Molly was born and we found out that she would have significant developmental delays and health concerns, we began seeking and asking for guidance, assistance and/or support so that we could provide for her in the best way possible. But consistently and without mercy, the answers came back: Never heard of her condition, aren't required to have support groups, she is not a priority population, her case isn't urgent enough, her case is too urgent, you make too much money, you can't afford our services, we cannot allow any more families to apply for that program, we can't hire any more case managers, we don't have any vendors that will serve children, we don't want to serve any more indigents, you need psychotherapy not family support. Probably by that time, I did.

My husband's business failed, my sons were showing signs of depression, I could no longer keep control of my emotions and was on the verge of a breakdown and Molly's condition worsened in that her seizure activity became more intense and frequent, she became spastic, almost rigid. In addition to the fact that she had been screaming constantly for almost 2 years as a result of her neurological imbalances.

We came face to face with a very difficult choice. Either let our family shatter and possibly never put the pieces back together or take drastic measures to get control of all of our lives. The only option we had available, if we were to work to rebuild our family, was to place Molly in institutional care. So Molly went to live away from us and, even though it was a nice respite, not having to hear her scream all day and night, or take 2 hours to feed her three times a day, we were also sad that she was not home where she belonged. Almost every weekend, we made the 4-hour one-way trip to see her. Her absence created a huge emotional void in our family's life.

On one such visit, we were not able to wake Molly up and her body felt cold to the touch. We took her to the emergency room to discover that she had a body temperature of somewhere just below 94 degrees. They admitted her and began administering warm IV fluids, had her under warm blankets and heat lamps. There was no indication of any infection or medication.

Despite these things, her temperature would not rise and at one point fell even lower. We were very, very scared and thought that maybe this was the end.

But, miraculously and all of a sudden, after 3 days, her temperature began to rise and she recovered. We then had to return home, leaving Molly at the institution which was extremely difficult.

The race was now on to find a way to bring her home with the proper supports. I attended a meeting and found out about a Medicaid program called the MR waiver for home and community-based support, a program that my State opted into to reduce the number of people being cared for in institutions. Perfect. This is exactly what we were looking for.

Well, 8 months and about 1,000 phone calls, letters and obstacles later, Molly was approved for waiver services. Some of the obstacles we faced along the way made it seem like nobody wanted Molly to live with her family and in her community. Molly's waiver services consist of her having an attendant to help care for her. Her attendant does all the things for Molly that she can't do and that you and I take for granted, like feeding ourselves or moving our arms and legs to keep our blood flowing and muscles from stiffening.

Molly, of course, is home and with me today and has been for a little over a year. She is doing wonderfully, she brightens up when she hears her brothers storming into the room, she smiles when she sees her dad, her brothers and me, her attendant and sometimes even at others who take the time to engage her glance.

Molly will never develop much beyond where she is now and will always require constant care. Pearl S. Buck wrote in her book, the "Gifts They Bring", that each life like a ripple in a stream affects every person with whom it comes into contact. The scope of one's activity may not be as extensive as another's but the impact of a life being good or bad has a profound and often lasting influence.

All I know is that Molly would not have gotten any care if the Federal Government had not recognized that States were not meeting the needs of its disabled citizens and provided leadership and funding incentives which had enabled States to move forward and develop such waiver programs.

Even with the matching fund incentive, many States choose not to participate in waiver programs because they don't view children like Molly as a priority. She will never be a voter.

Ensuring access to community-based supports and services is the right thing for Molly, her family and for her community. It is the right thing economically because it costs far less than institutional care and far more people can be served with the same amount of money. These positive steps should not be reversed.

Proposals to block grant or cap the Medicaid program with no Federal requirements to provide health, rehabilitation and home and community-based long-term care services and supports will in-

evitably lead to a reduction in critical services for the almost 5 million children and adults with disabilities currently being served and will indeed be a step backwards.

Mr. COBURN. Ms. Hantzes, I am going to ask you to try to finish up.

Ms. HANTZES. I have one more paragraph.

Mr. COBURN. Thank you.

Ms. HANTZES. Pearl Buck went on to say in her book that the test of any society is the manner in which it cares for the handicapped. As my story shows, the Medicaid long-term care program and specifically home and community-based waiver services are essential. You as leaders of this great country must recognize the moral obligations to serve those who are less able.

Thank you.

[The prepared statement of Brendy Hantzes follows:]

PREPARED STATEMENT OF BRENDA HANTZES

First, I would like to thank you for the opportunity to come and speak to you here today concerning my daughter Molly; the block granting of Medicaid and, specifically, the home and community-based waiver program that has enabled our family to survive despite the trying circumstances of caring for our profoundly disabled daughter. Please do not go forward with your proposals to block grant or cap Medicaid. I am afraid that if you do, our family will lose Molly again.

My name is Brenda Hantzes. In 1981, I graduated from college and moved to Washington, D.C. to begin work. That winter I met my future husband and we were married two years later. Along came the children—one, then two. We settled into a nice suburban lifestyle. My husband's firm was doing well, I was active as a volunteer both in the community and at my children's preschool.

Then along came child number three.

Molly, my long awaited daughter, was born with a devastating neural tube defect resulting in profound mental retardation, a seizure disorder, and a very shortened life span, so we are told.

And now, let me reintroduce myself.

We are the classic example of a family that has a child whose health and developmental needs are so great that unsupported—the family breaks. And that we did. But families don't just break on contact with a child with special needs. It is a slow, painful, brutal process of isolation, loneliness, and rejection by family, friends, neighbors, relative, and, often times, even from the very people whose job it is to provide services and support.

Almost from the first day Molly was born and we found out that she would have significant developmental delays and health concerns, we began seeking and asking for guidance, assistance and/or support so that we could provide for her in the best way possible. But consistently and without mercy, the answers came back, "never heard of her condition", "aren't required to have support groups", "she's not a priority population", "her case isn't urgent enough", "her case is too urgent", "you make too much money", "you can't afford our services", "we cannot allow anymore families to apply for that program", "we can't hire anymore case managers", "we don't have any vendors that will serve children", "we don't want to serve any more indigents", "you need psychotherapy not family support".

My husband's business failed; my sons were showing signs of depression; I could no longer keep control of my emotions and was on the verge of a breakdown; and Molly's condition worsened in that her seizure activity became more intense and frequent. She became spastic, almost rigid, in addition to the fact that she had been screaming constantly for two years as a result of her neurological imbalances.

We came face to face with a very difficult choice, either let our family shatter and possibly never put the pieces back together or take drastic measures to get control of all of our lives. The only option we had available if we were to work to rebuild our family was to place Molly in institutional care—temporary institutional care.

So Molly went to live away from us and even though it was a nice respite not having to hear her scream all day and night or take two hours to feed her three times a day, we were all so sad that she was not home where she belonged. Almost every weekend, we made the four hour one-way trip to see her. Her absence created a huge emotional void in our family's life.

On one such visit we were not able to wake Molly up and her body felt cold to the touch. We took her to the Emergency Room to discover that she had a body temperature of somewhat just below 94 degrees. They admitted her, began administering warm IV fluids, and had her under warm blankets and heat lamps. There was no indication of any infection or over-medication. Despite these things, her temperature would not rise and, at one point, fell even lower. We were very, very scared and thought that maybe this was the end. But miraculously and all of a sudden, after three days her temperature began to rise and she recovered.

We then had to return home leaving Molly at the institution, which was extremely difficult. The race was now on to find a way to bring her home with proper supports. I attended a meeting and found out about a Medicaid program called the MR waiver for home and community-based support, a program that my state opted into to reduce the number of people being cared for in institutions.

Perfect, this was exactly what we were looking for.

Well, eight months and about a thousand phone calls, letters, and obstacles later, Molly was approved for waiver services. Some of the obstacles that we faced along the way made it seem like nobody wanted to help Molly live with her family and in her community. Molly's waiver services consist of her having an attendant to help care for her. Her attendant does all the things for Molly that she can't do and that you and I take for granted, like feeding ourselves or moving our arms and legs to keep our blood flowing and our muscles from stiffening.

Molly, of course, is home now and has been for a little over a year. She is doing wonderfully. She brightens up when she hears her brothers storming into the room; she smiles when she sees her dad, her brothers and me, her attendant, and sometimes even at others who take the time to engage her glance. Molly will never develop much beyond where he is now and will always require constant care. Pearl S. Buck wrote in her book, *The Gifts They Bring*, that:

> Each life is like a ripple in a stream, affects every person with whom it comes into contact. The scope of one's activity may not be as extensive as another's but the impact of a life, be it good or bad, has a profound and often lasting influence.

All I know is that Molly would not have gotten the care she needs if the federal government hadn't recognized that states were not meeting the needs of its citizens with disabilities and provided leadership and funding incentives which have enabled the states to move forward and develop such waiver programs. Even with the matching fund incentive many states choose not to participate in the waiver programs, because they do not view children like Molly as a priority. She will never be a voter.

Ensuring access to community-based supports and services is the right thing for Molly, her family, and for her community. It is the right thing economically because it costs far less that institutional care and far more people can be served for the same amount of money. There positive steps should not be reversed.

Proposals to block grant or cap the Medicaid program, with no federal requirements to provide health, rehabilitation, and home and community-based long term services and supports will inevitably lead to a reduction in critical services for the almost five million children and adults with disabilities currently being served and will indeed be a step backwards.

Pearl S. Buck went on to say in her book that "the test of any society is the manner in which it cares for the handicapped". As my story shows, the Medicaid long term care program and, specifically, home and community-based waiver services are essential and you, as leaders of this great country, must recognize the moral obligation to serve those who are less able.

Thank you for this opportunity. Testimony that was submitted for the record by the Consortium for Citizens with Disabilities goes into greater detail about the things that I have brought up to you today.

Mr. COBURN. Thank you very much.

Ms. Koyanagi, I would like to apologize for not recognizing you, and I would like to ask you to go next, if you would, please.

STATEMENT OF CHRIS KOYANAGI

Ms. KOYANAGI. Thank you, Mr. Chairman.

My statement is presented on behalf of 11 national organizations concerned about mental health treatment under Medicaid and I should state at the opening that I am not going to address the broader issues of block grant cuts and cost controls in Medicaid but

would be happy to answer questions on that should you wish to do that afterwards.

I wanted to brief the members of the committee first on the importance that Medicaid has played in the mental health system over the last 10 to 15 years. In mental health, the State has been the primary deliverer of services and the organizer of care and States have been adjusting their priorities in mental health to move toward a broad array of community treatments, even for those with the most serious disabilities, both adults and children. And Medicaid has played a vital role in helping them to follow that policy.

Since the mid-1980's, States have created ways of working with the services defined in Medicaid to fund everything from day treatment programs, rehabilitation, individualized case management teams that work with even the most severely mentally ill people, some of whom may even be homeless, and have used Medicaid dollars increasingly for these purposes. As a result of this, Medicaid is now contributing some 19 percent of the resources spent on public mental health services. We know though that that is an undercount of overall mental health spending in Medicaid and the problem is we cannot track mental health data within Medicaid in part because the services are subsumed in broader categories and you cannot always determine from the data what is spent on a mental health clinic service versus a physical clinic service.

Because of the importance of Medicaid within mental health systems, and the importance of mental health within Medicaid, we urge you to really take a careful look at the impact of any changes you are about to write in terms of those who are fully dependent on the public sector for their care. And my testimony really addresses those with the more severe disabilities, both adults and children, for whom the public mental health system and the Medicaid program are vital components.

We would like to urge in our recommendations that first of all you clarify for the States the mental health services that are reimbursable under Medicaid. Even as you move to a broader and more flexible program, it is going to be essential for States to know what you consider a health service and in mental health even more than physical health, that line is sometimes hard to see.

What we would like to see is the services that States have been able to use under Medicaid continue as options and clearly articulated in the statute. This will, we think, enhance the provision of managed care for this population and States begin to move in that direction by helping to explain to managed care companies what is a coverable service and we think it also will help us with data collection and Federal and State policymakers need to know where the money is going. And without those separate categories, we won't get the data in a manner which enables us to see where the mental health dollars are going.

We also are, I would say, nervously optimistic about managed care and Medicaid for this population and most of the managed are in Medicaid to date has been for the AFDC and low-income populations. States have only recently begun to move toward populations with disabilities such as those with severe mental illness. However, in public mental health, we have spent maybe 25 years

trying to develop comprehensive and flexible community systems of care for people with mental illness and managed care is in fact the same concept.

So if well implemented, we feel we would like to see how the private sector could do since the public sector has never been able to move these systems much beyond the demonstration stage, despite some very positive evaluations of cost effectiveness and the private sector has in fact found some significant cost savings in approaching managed care for mentally ill persons within private insurance.

So we would like to see some national standards on managed care in, in fact, my testimony I should point out, is also endorsed by the organization that represents managed behavioral mental health companies and they too endorse some national standards around the operation of managed care. So I think that we would be happy to work with the committee in terms of specifics there and I think that is very, very important.

One of my most important recommendations, though, is that you include in the Medicaid legislation language which will prevent discrimination against people with mental illnesses. We have for many, many years operated systems where mental health care is seen as secondary to other services. I think we have passed that point. I think we have the scientific research on the functioning of the brain and the research on the effectiveness of treatments that shows us that this is both poor policy and we also have the information from the public from opinion polls that have been conducted recently that this is no longer what the public is looking for.

As we move to flexibility in Medicaid, I think an underpinning principle of nondiscrimination against persons with mental illness is of critical importance.

I see my time has expired so I will wrap it up with two very short recommendations. One, we continue to be concerned about population dependent on Medicaid because of SSI eligibility and would urge that that requirement remain in the program and second we also remain very concerned that States continue to contribute their resources to the program and we would support a maintenance of effort on the States.

Thank you, Mr. Chairman.

[The prepared statement of Chris Koyanagi follows:]

PREPARED STATEMENT OF CHRIS KOYANAGI, CO-DIRECTOR FOR GOVERNMENT RELATIONS, BAZELON CENTER FOR MENTAL HEALTH LAW

Mr. Chairman, Members of the Subcommittee, my name is Chris Koyanagi and I am Co-Director of Government Relations for the Bazelon Center for Mental Health Law here in Washington, D.C. My statement today is made on behalf of the Bazelon Center and the national mental health organizations representing consumers, family members, states, managers and providers which are listed on the front of this testimony. In addition, this statement is consistent with written testimony submitted to the subcommittee by 26 organizations in the Mental Health Liaison Group.

Medicaid and Mental Health

Medicaid represents a major source of financing for mental health care, particularly for adults with serious mental illness and children with serious mental and emotional disturbance. In many states, Medicaid supports about one-third of state and county mental health systems, and is particularly important as a funding source for community mental health services. In 1990, the National Association of State Mental Health Program Directors estimated that at least $8.1 billion, or 19% of the total $42.4 billion of public and private spending on mental health services

in that year, came from Medicaid.[1] States have increasingly used Medicaid funds to target community services to children with serious mental and emotional disturbance and adults with serious mental illness. In this manner, Medicaid has played a very significant role in encouraging the expansion of community-based treatments which are effective for seriously impaired children and adults, such as psychiatric rehabilitation, day treatment programs for children, case management and other intensive community services.

Spending on mental health within Medicaid is also significant. However, despite increases on the community side, most Medicaid funds continue to go towards institutional services. While Medicaid mental health spending is relatively high, much of that cost is accounted for by spending on hospital and other institutional services. Recently this pattern has begun to change as states emphasized community-based treatment, but since 1990, states have added over $3 billion to mental health spending under Medicaid through disproportionate share payments. Another $2.9 billion is spent on services in institutions for mental diseases. While, according to the National Association of State Mental Health Program Directors, community spending has increased to a little over $2 billion, community services still represent a small proportion of total Medicaid mental health spending.

Adults and children with serious disorders generally become eligible for Medicaid coverage through the SSI program, although in certain states significant numbers may be covered under medically-needy options. While other low-income populations covered under Medicaid also have mental health needs, most individuals covered through AFDC or because of low income do not require the range of mental health interventions that are necessary for persons disabled by mental illness. Currently about 2 million adults and children with mental illness disorders are eligible for Medicaid because of their SSI eligibility.

Covered Services

Medicaid services of importance to mental health are generally to be found in the optional categories. In the mandatory services, the most significant services for adults are inpatient and outpatient general hospital services and physician services. In addition, of course, current law mandates through the EPSDT program a full range of mandatory and optional services for children.

Optional Medicaid services which are relevant to mental health care are not easy to identify unless you know the program very well because they are not listed as specific mental health services but included within much broader categories. These optional services are:

- Other diagnostic, screening, preventive and rehabilitative services, which is used to cover psychiatric rehabilitation for adults and children in 33 states.
- Clinic services, which in 39 states include mental health clinic services.
- Prescription drugs, covered in all states.
- Targeted case management, covered for adults with mental illness and/or children with serious emotional disturbance in 39 states.
- Services of other health professionals, used to cover clinical psychologists in 38 states and clinical social workers in 5 states.
- Personal care services, covered for persons with mental illness in 13 states.
- Inpatient hospital services for children under age 22, including services in residential treatment facilities, covered in 44 states.
- Inpatient services for adults over age 64, covered in 45 states.

Amendments to Medicaid

We support reforms in Medicaid to improve the services for adults and children with mental and emotional disorders. We do not oppose proposals to achieve cost economies. However, the two objectives must be linked. That is, efforts to reduce costs must be carefully crafted with the short and long-term consequences on beneficiaries uppermost in mind. In this context, we believe that Medicaid could be more cost-efficient if it expanded access to home and community based services, increased access to a comprehensive array of services through managed care plans with appropriate quality and performance safeguards. We also support increased opportunity to foster integration of mental health with other health care.

Recommendations

1) *Services.*—The range of mental health services which can now be furnished under Medicaid should be more clearly stated in the law. As greater flexibility is granted to states, and particularly as managed care options expand, it is extremely

[1] Richard G. Frank, Thomas G. McGuire, et. al. "Paying for Mental Health and Substance Abuse Care," *Health Affairs,* Spring (I), 1994, p 336.

important that the array of services developed by states over the past 10-15 years be clearly stipulated as coverable services. Our recommendations do not represent any expanded mandate on the states nor any expansion of federal commitment for new mental health services. However, we urge that a clear listing of the optional Medicaid mental health services be made in the statute, as follows: Screening, assessment and diagnosis; Crisis services; Psychotherapy and collateral services; Medication management; Substance abuse counseling and relapse prevention; Psychiatric rehabilitation, day treatment services for children; Partial hospitalization services; Intensive in-home services Ambulatory detoxification services; Case management; and Prescription drug coverage.

Each state should then annually disclose in its state plan the mental health and substance abuse services it will provide and the amount of money it will spend (and what it did spend in the previous year) on all mental health and substance abuse services.

The current law for mandatory coverage of inpatient hospital services and for physician services should be retained.

These recommendations assume that the committee will continue a Medicaid program that includes both acute and long-term care. Should Congress consider the differential treatment of long term care and acute care under Medicaid, then it is important that community-based long term care for persons with mental illness be part of the long-term care program.

2) *Nondiscrimination.*—The Committee has the opportunity, as it rewrites Medicaid law, to address the historic bias against mental health services in third party reimbursement systems. While most state Medicaid programs provide a substantial mental health benefit, we nonetheless believe that it is appropriate for the federal government to ensure that the principle of non-discrimination on the basis of diagnosis be underscored. Accordingly, we urge the Subcommittee to require that any state participating in the Medicaid program implement its Medicaid plan in a manner which does not discriminate against individuals with mental illness. Nondiscrimination requires that the state provide coverage of services for mental illness in a manner which is equitable and commensurate with the coverage of other conditions and that the state not impose day or visit limits or cost-sharing requirements on mental illness services that are not applied to other medical conditions. Nondiscrimination does not prevent a state from requiring pre-admission screening, prior authorization of services or other mechanisms limiting coverage to services that are deemed medically necessary.

Mental and emotional disorders are an integral part of health care. Scientific evidence and societal attitudes have coalesced toward an understanding of these disorders as major health problems which, when untreated, generate considerable social and economic costs. There is no longer (if there ever was) a reasonable rationale for providing coverage of effective treatments for diabetes, for example, but not for effective treatment of schizophrenia.

It is increasingly recognized that treatment for mental illnesses yields important benefits such as improvement in overall health, reduced health care costs, increased productivity, improved educational performance by youngsters, and potential savings in social welfare and criminal justice expenditures. Scientific evidence and experience have led to the recognition that a comprehensive array of services, along with flexibility to provide such services to individuals based upon medical and psychological necessity, produces better outcomes than traditional benefits with arbitrary limits on services.

During last year's health care reform debate the public expressed strong support for treating mental and physical illnesses the same. A public opinion poll conducted by the Bazelon Center for Mental Health Law found that 82 percent of registered voters think someone with a mental illness is as sick as someone with a physical illness and 78 percent think mental health should be covered to the same extent as physical illness. An even higher percentage think it important to cover children's mental health services (85%).

3) *Program Standards.*—Each state should set up and publish its own program standards—and provide the opportunity for citizen input—to ensure quality and facilitate accountability.

4) *Managed Care.*—States should have greater flexibility to establish managed care networks, including the use of the regular state plan amendment process. State Medicaid managed care programs should include the full array of mental health services, including inpatient, residential and community services, and states should have flexibility to determine who should provide the service and how the services are provided.

Managed care must have strong and uniformly applied patient protections and standards to ensure access to quality treatment throughout the full continuum of

care. Flexibility in managing mental health care must not mean denial of appropriate care in order to reduce costs or operate within budget limits. Basic federal standards for the operation of Medicaid managed care plans should be established in the statute.

5) *Eligibility.*—Eligibility for Medicaid should be streamlined and generally based upon income. However, the federal government should continue to require coverage of individuals who are eligible for SSI and, at the state option, individuals who are "medically-needy". People with disabilities and serious chronic illnesses must have access to health care services. Such individuals have extraordinary health care needs, and costs, and if left without access to care their conditions are likely to deteriorate, requiring more intensive and more costly institutional services in the future.

6) *State Maintenance of Effort.*—The Budget Resolution has mandated major cutbacks in federal Medicaid spending. Improved operation of the program and increased use of managed care and other techniques to streamline delivery will enable states to compensate for some of these cuts. However, it is clear that the proposed reductions, particularly in future years, will result in significant cuts in services and/or in the population eligible for Medicaid. It is imperative that we not add to that scenario of massive further cuts in health care for the poor by allowing states to withdraw their own resources from the program. States must be required to continue at least their current spending and preferably, to continue to their match federal contributions.

Thank you for the opportunity to testify.

Mr. COBURN. Thank you very much.

Mr. Barnes, could you please?

STATEMENT OF MARK BARNES

Mr. BARNES. Thank you, Congressman Coburn.

I am Mark Barnes and I am here today representing people with AIDS across the country and all of their many medical and social service care givers across the country. We represent 1,000 of those eight service organizations, medical and social service organizations at AIDS Action Council.

Preserving the essential Medicaid funding and the Medicaid entitlement with minimum national standards for quality AIDS care and treatment, we think, is really a life or death matter for people living with HIV across the country. There are about a million people estimated across the country infected with HIV and somewhere, depending on whose estimates you take, between 40 and 60 percent of those people are Medicaid eligible and dependent on Medicaid directly for their base line medical care. Medicaid also is the payer of first resort for about 90 percent of the children living with HIV across the country.

Medicaid is not just a program for the indigent. In the case of people with AIDS and families who are affected by the epidemic, Medicaid is in many cases a safety net for middle class people who have become impoverished through illness and for whom, after they spend down their assets and after they go on unemployment and become quite ill, Medicaid is the ultimate safety net for them.

Only a few weeks ago this committee considered and passed unanimously the Ryan White Care Act and we in the national AIDS community are deeply, deeply grateful to this committee for its very strong support of that act. Yet, in the full spectrum of AIDS care, the Ryan White program is a gap filler. It is the payer of last resort in many cases for the working poor and those who are uninsured and underinsured but it doesn't take the place of Medicaid.

For the uninsured population, however, Ryan White does pay for primary care and lifesaving drugs. But for people who are HIV ill

and who no longer work and who spend down their assets which, by time of death, is a majority of AIDS patients, Medicaid is this last ultimate safety net.

Adequate Medicaid coverage for the AIDS population, we believe, and we think that there are statistics to show this, adequate Medicaid coverage for the population of people living with HIV and AIDS actually reduces cost because it leads to reductions in hospitalization and to nursing home stays and therefore saves both money and lives.

In considering the effect of any reform in Medicaid, whether it is cost caps, block granting or a move toward Medicaid managed care for people with HIV and other disabilities, the national AIDS community asks that this committee consider very carefully the impact of any of those moves on the still new and in many cases very fragile AIDS care infrastructure that has been built up across the country and on these fragile AIDS care partnerships that have been built up in clinics and community health centers and public hospitals and private hospitals around the country because for all of these entities, Medicaid is the ultimate financial base on which the entire care system is built.

And I would like to give you briefly two examples of these care partnerships, these public/private care partnerships across the country.

First, in New York City, there is a Catholic hospital, it is owned by the Sisters of Charity, which is a Catholic order of nuns. It is called St. Vincent's Hospital. They have an outpatient clinic there, an AIDS outpatient clinic that serves 2,000 HIV positive patients per year, 15,000 annual visits. Seventy-four percent of their patient population is Medicaid eligible, 1 percent Medicare eligible. All the rest are uninsured. A very small proportion, less than 1 percent, are private insurance or private pay.

Doctors, nurses and social workers in this clinic, they work in a small, crowded and often a very chaotic setting, working in most cases at half the salaries they would receive elsewhere if they were in academic medical specialties or in private practice. Yet together they have put together a funding package that keeps the clinic running and in some cases even solvent on a month-by-month basis.

Medicaid fee-for-service is the base. To that, there is a Ryan White Title III(b) grant, there is a Ryan White Title I grant that pays for the uninsured portion of the people who are patients there, and Ryan White Title II pays for the AIDS drugs for people who are uninsured. Then there are some small foundation grants from the community trust and private foundations that help with social work services and some prevention education among the HIV-infected population.

At another Catholic hospital 40 blocks north at St. Claire's, also the financial bedrock of that program is fee-for-service Medicaid. Fifty-four percent of its patients are Medicaid eligible and that is the bedrock. But to that they add 300 volunteers and Mother Theresa's Missionaries of Charity provide the hospice care with no fee-for-service reimbursement at all; they do it all by themselves.

On another coast, in Los Angeles, we have the AIDS Health Care Foundation, 2,500 patients served every year. They actually have a Medicaid managed care product for people with AIDS which

seems to work pretty well, although it is small and growing. And they take the Ryan White money, their Medicaid money and they put it all together and they add to it about $2 million a year in private fundraising including four thrift stores that are run all over Los Angeles to add to this.

In all of these cases, what we are talking about when we talk about people with AIDS and families living with AIDS is a public/private partnership and care. But the base of it really is the Medicaid fee-for-service reimbursement system and it is really essential that we believe that that funding stream be preserved.

The AIDS care community understands that Congress is in a difficult situation with the cost reforms and the need to control costs in Medicaid. But at the same time, we believe that there are lessons that the AIDS community can teach in terms of shifting money and resources into outpatient care, forming public/private partnerships and in all of these ways, we urge you as you move forward in cost containment, don't undertake far-reaching changes that might imperil this very fragile infrastructure. Don't end entitlement status before examining the full impact on these community organizations and these fragile hospital systems. Don't block grant when that means or if that means less money for hospitals and care providers who are struggling as it is and don't rush into Medicaid managed care as a panacea without some very tough minimum standards of care so that this population will be protected.

Thank you very much.

[The prepared statement of Mark Barnes follows:]

PREPARED STATEMENT OF MARK BARNES, EXECUTIVE DIRECTOR, AIDS ACTION COUNCIL

Mr. Chairman and Members of the Committee: My name is Mark Barnes and I am the executive director of AIDS Action Council. I am pleased to be here this morning to testify as to the importance of Medicaid to the people we represent: people living with AIDS and the providers caring for them. AIDS Action Council represents over 1000 community organizations throughout the nation providing medical and social services to people and communities affected by the AIDS epidemic.

We testify today in strong opposition to the proposed block granting of Medicaid, to the ending of Medicaid's status as an entitlement, and to the imposition of growth caps. Originally enacted in 1965 as companion legislation to Medicare, Medicaid has been on the front lines in meeting the health needs of our nation's most vulnerable populations. For more than 30 million people Medicaid represents an essential source of health coverage.

Medicaid is of critical importance to people with HIV/AIDS. Over one million people are infected with HIV. The highest prevalence of AIDS is in four states: New York, California, Florida and Texas. But as the AIDS epidemic grows it has spread beyond these urban areas into every state in this country. There are AIDS cases in Kentucky and Indiana and Arizona. There are AIDS cases in Fort Wayne, Chattanooga and Cedar Rapids. According to the Centers of Disease Control, AIDS is the leading cause of death among all Americans between the ages of 24 and 44. The CDC also reports that the total number of deaths from AIDS is 270,870, including 267,479 adults and adolescents and 3,391 children. Medicaid pays for the care of 40 percent of everyone living with AIDS nationally and over 60 percent in some states. Medicaid pays for the health care for 90 percent of the children living with AIDS.

A recent study by the National Public Health and Hospital Institute found that Medicaid is the largest source of health insurance for people living with HIV, providing access to physicians, hospitalization, prescription drugs and medical supplies, home health care, clinic and outpatient care, mental health and substance-abuse treatment, and hospice and long-term care (including nursing home care, home care and community-based care).

Medicaid is not simply a program for the indigent: especially in the case of AIDS, Medicaid serves as a safety net for middle-class people who have lost their health insurance and who have become impoverished by paying for medical care. It is an all-too-common progression from being too sick to work, to losing medical insurance, to spending down all one's assets, to qualifying for and going on Medicaid.

Indeed, for people with AIDS, this process is not unlike that experienced in the process of aging: gradual disability and illness, loss of social group through death, and gradual impoverishment. The major difference in AIDS is that this process is defined in months, instead of years or decades. For this reason, many people living with AIDS do not live long enough to qualify for Medicare, which is available only to those who are seniors or have been on disability for more than two years. They are left with Medicaid as their only source of health care.

Congress has passed a budget calling for $182 billion in savings from the Medicaid program over the next seven years. This money is coming from capping Medicaid's growth below its projected needs. Specifically, the budget calls for capping Medicaid's growth at 7.2 percent the first year, 6.8 percent the second year, and 4 percent the remaining five years. This is well below Medicaid's past expenditure growth and its future projected rate of growth. Medicaid is projected to grow nationally over 10 percent during the next seven years. It is likely to grow much more in states with growing populations. In individual states like Texas the annual average rate of growth has been 28 percent. In Virginia the rate is 18.2 percent and in Florida 26.1 percent.

Many believe that the way to achieve these savings is to "block grant" Medicaid, thus ending its status as an entitlement program. Some governors and other state officials have testified before this Committee and the Senate Finance Committee in favor of these block grants. They argue that states can allocate money for Medicaid better than the Federal government. They further propose that they can run the program for less money through the implementation of managed care. Although we recognize the need for efficiency in all medical care, including that for the indigent, we have serious concerns about ending Medicaid's status as an entitlement, block granting Medicaid, and moving the Medicaid population into managed care without careful planning and tough protections.

Maintain Medicaid's Status as an Entitlement: Don't Block Grant

We believe that the impact of a block grant and the loss of Medicaid as an entitlement would be disastrous for people living with AIDS. People living with AIDS have a broad range of needs stemming from the all-out-attack that AIDS wages on the immune system. For example, people with AIDS rely on a broad range of prescription medicines that fight infections and slow the progress of the disease. These medicines often cost as much as $3,000 for a month's supply, and people living with AIDS often take ten or fifteen different medications. People living with AIDS have a heightened need for mental health care, substance abuse treatment and hospice and home health care, in addition to primary care and hospital services. They need to consult with nutritionists in order to fend off the wasting away that often accompanies AIDS. Under current law, there is no federal requirement for states to provide many of these services, although a number of states offer some of these critical optional services because they contribute to a reduction in expensive hospitalizations. It remains to be seen whether states will be in a position to offer any of these so-called "optional services," including prescription drug benefits, home-based and hospice care, with any reduced federal Medicaid allotment that will come with the implementation of the budgetary savings for Medicaid outlined in the Budget Resolution.

Second, what will happen with Medicaid eligibility if this program is block granted to the states? Now, everyone who meets the disability and income standards of Medicaid is guaranteed coverage. Without such an entitlement, states will have to choose who among the eligible will receive services. Moreover, many states, like Tennessee and Arizona, have expanded Medicaid coverage beyond the minimum federal requirements. They include the medically needy, like people with AIDS, who are spending large portions of their income for medical care. Without the money to keep up with growth rates, states will have to cut even the eligible population from the program. People with AIDS who are receiving Medicaid as medically needy persons could be one of the first groups cut from the rolls.

Even if states are able to accommodate the same number of people at the beginning of a fiscal year, they will find it more and more difficult to do this as the fiscal year goes on. With projections of growth in the number of people needing Medicaid services, states will find that they cannot provide Medicaid services to people who become ill later in the year. This could result in waiting-lists for care. Delays in care are particularly harmful to people living with AIDS because early intervention and

treatment can forestall the deadly infections which attack people with damaged immune systems. It is precisely such early intervention and treatment that serves to reduce health care costs by eliminating the need for costly hospital stays.

We worry, too, that people living with AIDS could be discriminated against in receiving health care, as they so often are in housing and in the job market. Without any intent to discriminate, states may be inclined to determine eligibility in a way that reduces costs, but also disproportionately harms people living with AIDS who are in need of preventive treatment even before becoming demonstrably ill. We worry, in short, about whether people with HIV infection will receive differential, sub-optimal treatment in some states' Medicaid programs under a pure block grant approach.

Most importantly, there is no real savings involved in delaying or denying treatment to people living with AIDS. People living with AIDS will get sick and will appear for emergency care. Someone will have to pay for their care whether it is from the Medicaid block grant or state, local, or county resources.

Issues Regarding Medicaid Managed Care

We have two concerns regarding Medicaid managed care: (1) can it really provide savings and (2) can it really provide quality care to the chronically ill?

Will Medicaid Managed Care Provide Savings?

It is a matter of some dispute that nation-wide managed care can result in a level of savings which would make up the decrease in money available to serve people in need. The Kaiser Commission on the Future of Medicaid wrote recently that "while many programs appear to achieve some cost savings, others claim that they operate at costs similar to or above those expected of traditional Medicaid programs." In states which have already received waivers and have moved their Medicaid population into managed care, there is very little fat available for cutting. Since it is likely that future funding levels will be set according to FY 1995 expenditures, states like Arizona and Tennessee will find that they will be punished—not rewarded—for lowering costs. Without the hoped-for savings from Medicaid managed care, many states will be faced with a growth in their Medicaid budget falling far short of the growth of those in need of care.

Will Medicaid Managed Care Provide Quality?

There are a number of questions about managed care's ability to provide quality care for people living with AIDS. Managed care has almost no track record in caring for people with chronic diseases such as AIDS. Most participants in a managed care plan are working adults and their generally healthy families. The financing of managed care plans through capitation rates reinforces their emphasis on the young and healthy: a specific amount of money is provided per patient. This creates an incentive to deliver as little care as possible, not to reach out to meet the long-term and costly needs of the chronically ill. Another aspect of quality is access to care. Many managed health plans do not have the capacity to handle the large influx of Medicaid recipients living with AIDS who will become clients. A number of states which obtained waivers to channel their Medicaid population into managed care are enrolling the relatively healthy women and children in the Aid to Families with Dependent Children program first, and are waiting before enrolling their disabled population. Where they have not done so, states have faced difficulty providing services to the disabled population. For example, in New York the health maintenance organization run by the city's public hospitals had agreed to suspend enrollment of new members from Medicaid for 30 days because of concerns of complaints about long waits, often of up to several weeks, to see a doctor. Moreover, managed care plans that are providing care for people living with HIV often do not provide access to HIV specialists. They also sometimes do not provide full access to therapeutic and prophylactic drugs vital to people living with AIDS. In AIDS these concerns are particularly acute not only because of the chronic and degenerative nature of AIDS, but also because of the newness of this disease and the rapidly-developing nature of treatments.

If Congress takes legislative steps that will expedite the movement of the Medicaid program toward managed care, we believe that tough, explicit federal minimum standards must be included. As a starting point for discussion of how people with HIV can be protected and efficiencies also gained in Medicaid managed care, we offer the following draft suggestions for federal quality standards for people with HIV/AIDS in Medicaid managed care as an addendum to this testimony.

These standards represent our best efforts at setting minimum standards for managed care plans that care for the chronically ill, like people with AIDS. The most important overall standard is that capitation rates be set in a way that provide adequate reimbursement for the entities running the plan. This is especially impor-

tant regarding reimbursement for new therapies and new drugs. Without reasonable reimbursement it is not possible to hold plans to an appropriate standard of quality assurance.

In the absence of comprehensive health care reform, the Medicaid program offers a lifeline and a safety net to individuals living in poverty, those rejected by the private health insurance system because of pre-existing conditions, and those who have been impoverished and/or disabled by serious illness. For many thousands of Americans, it is the only access point for health care. These American families who depend upon this program and their health care needs will not disappear, even if the nature and scope of the program are so profoundly reduced that families lose their eligibility or lose access to many of the health care services they depend upon. The human toll of ending the entitlement status of Medicaid will be devastating and, in the case of AIDS, will undoubtedly include premature loss of life. The financial toll on city, county and state government could also be profound as Medicaid-eligible individuals and families turn to costly emergency room care as their only recourse to obtain the health care services they so desperately need.

We respectfully ask that this Committee think and plan carefully before enacting legislation that might undermine the access to health care for thousands of families affected by HIV.

Thank you very much for the opportunity of testifying today. I look forward to answering your questions and providing any assistance AIDS Action Council can in the weeks and months ahead.

Specific Recommendations for Managed Health Plans Serving People Living With AIDS

1. *Capitated rates that the state negotiates with managed care plans should be risk-adjusted, and must reflect the true costs of medically necessary HIV care.* To hold plans harmless from financial loss based on new treatments/therapies, retrospective rate appeals should be allowed, and criteria should include these unexpected/unforseen costs of newly-emerged treatments. Further, states should consider offering directly or encouraging the Medicaid managed care plans to purchase "stop-loss" insurance, which would hold the plan's total possible loss per patient to a definite "deductible" amount.
2. *Drugs and laboratory services should not be included in capitated Medicaid managed care rates, since the costs of these items are so unpredictable when treating patients with HIV disease.* Alternatively, if drugs are included in capitated rates, there should be some "stop-loss" protection for Medicaid managed care providers. To the extent that plans do pay for drugs, they should be required to pay for the full range of FDA-approved drugs including those for "off-label" administration.
3. *Each patient must have access to a primary physician provider with expertise in the treatment of HIV disease.* To do this, some states may choose to develop HIV-specific Medicaid managed care plans (often termed "Special Needs Plans") that are contractual alliances of existing HIV care providers (*e.g.*, hospitals, clinics, community health centers AIDS services organizations, substance abuse and treatment centers, and hospices and home-care providers. In those states that do not have such HIV-specific plans, or in geographic areas in which such plans are not available or feasible (due to low numbers of the HIV-infected), all managed care plans should be required to contract with existing HIV care providers and to reimburse those providers at a reasonable rate for medically necessary services they provide to the HIV-infected. The types of providers with whom they should be obligated to contract include: all Ryan White and HOPWA-funded entities, NIH AIDS Clinical Trials Group (ACTG) sites, other NIH-funded clinical trial sponsors, and such entities as designated by state or local health departments as having the requisite expertise in HIV care.
4. *HIV-specific quality assurance, including patient satisfaction indices, must be undertaken by each managed care plan that provides services to the HIV-infected, in accordance with standards promulgated by federal, state or local Medicaid authorities.* State and local authorities should have access to patient records to fulfill this oversight role.
5. *Prospective and current enrollees should be provided quality assurance results, and comparative quality assurance results should be made available at times of enrollment and potential disenrollment.* Available statistics should include length of time of survival after diagnosis, outcome measures (if available), prescription medication/formulary availability, and provider/patient satisfaction measures. In addition, plans must provide their enrollment and disenrollment data to an independent party who will see to it that people living with HIV/AIDS are not disenrolled from the plan when their care becomes expensive.

Monitoring both voluntary and involuntary disenrollment is critical because either could be the result of a plan's failure to provide the services for which it contracted with the state.

6. *Each Medicaid managed care plan should offer and encourage voluntary HIV testing of sexually-active adults or those who have a history of substance abuse or addiction.* When a patient has been identified as HIV-infected, the patient must be afforded the right to disenroll in a plan and enroll in another plan with greater HIV expertise.
7. *Adequate HIV care in a Medicaid managed care plan must include access, as medically appropriate, to the specialties of gastroenterology, infectious diseases, psychiatry, dermatology, nephrology, cardiology, surgery, obstetrics-gynecology, hematology/oncology, ophthalmology, otolaryngology, and neurology.* All managed care plans must have agreements or contracts in place to allow patients to have access to these specialists, as medically indicated.
8. *Services that must be included in managed care plans for the HIV-infected include: substance abuse treatment, mental health services, obstetrician-gynecologist's care, primary medical care, case management, prevention counseling, home care and infusion therapy, nutrition counseling, dental services, and long-term and/or hospice care for those in the terminal stage of their illness.*
9. *Medicaid managed care plans should have expedited grievance procedures and appeals mechanisms for patients and their primary providers/"gatekeepers."* Such grievance procedures should allow patients and providers to attain meaningful review and right to be heard within 24 hours of the denial of service. Grievances must be reviewed periodically by an impartial third party.
10. *Medicaid managed care plans should facilitate the participation of people with HIV in clinical trials and provide ancillary medical care during the trial.*

Mr. COBURN. Thank you.

Mr. Warden.

STATEMENT OF GAIL WARDEN

Mr. WARDEN. Thank you, Mr. Chairman.

I am Gail Warden, the President and CEO of the Henry Ford Health System in Detroit and the current Chairman of the Board of Trustees of the American Hospital Association. I am pleased to be here today to testify on behalf of our 5,000 diverse members who are hospitals, health systems, networks and other providers of care across the country.

From our perspective, current Medicaid debate must be put in the context of striking a careful balance. On the one side is a legitimate need to moderate rising Medicaid costs. On the other side, however, is our responsibility as health care providers to maintain values that led to the establishment of the Medicaid program in the first place.

There are two major points we want to make today. First, we must never lose sight of the people served by Medicaid and we have heard about that here this morning. The greatest proportion of Medicaid recipients are children. We cannot expect them to grow up and become productive workers and parents of the next generation if their basic health needs are neglected. And the greatest share of Medicaid dollars, of course, go to the poor, disabled and elderly.

Our written statement highlights actual case histories from hospitals across the country of typical Medicaid beneficiaries and they are not unlike what you have heard about today.

Second, we believe there should be reasonable Federal safeguards that should be built into any changes Congress proposes for Medicaid. We believe Medicaid could be more efficient but there are limits to the savings. It would only be prudent to attach some basic Federal conditions to those dollars, conditions that would not, how-

ever, call for the complex compliance procedures or give rise to a new bureaucracy.

On behalf of America's taxpayers, we believe the Federal Government simply can be a prudent buyer, as it is in the business world, and such conditions could basically be characterized as basic contractual obligations.

Earlier this year, the American Hospital Association appointed a task force drawn from our diverse membership to help sort out the basic principles that we felt should guide long-range Medicaid changes in today's era of cost restraint. These principles are grouped under two headings and each is important.

The first group is the Federal standards for increased State Medicaid flexibility and a second group building a framework for Medicaid payment safeguards.

Under the area of Federal standards for increased State flexibility, we believe it should include, No. 1, a determination of Federal financial participation for each State based upon annual changes in population and inflation as well as taking into consideration the disproportionate share institutions in that particular State, as you know, it differs from State to State.

Second, we believe that there should be a requirement that States maintain a continued proportional financial commitment to Medicaid and that they ensure that the program funds are spent on providing health care services to eligible beneficiaries.

Third, that Medicaid eligibility be based on income and need, with the eligibility process clearly defined. That States continue to provide both acute care and long-term care services to beneficiaries and that they encourage health care innovations such as integrated delivery systems and the ability to restructure the system and therefore become more cost effective.

And also that there should be regular reports from the States setting out their progress toward national goals for improving the health status of the Medicaid population.

On the safeguard side, if the Boren Amendment is to be changed, we would propose a new framework for payment safeguards drawn from the objectives of the original Boren Amendment. We believe payment safeguards should include a public hearing and comment process for establishing payment rates, that there should be use of an independent actuary to certify that the rates are reasonable and adequate, that the States should assure the secretary of HHS that public process and payment rate adequacy standards have been met and that there be a legal standing for health care providers to seek legal recourse if they believe rates are inadequate and there should be public disclosure by health plans of rates paid by providers.

We are proud of the role that hospitals and health systems play as health care innovators. We included some of that in our written testimony. We believe that the Medicaid program should be a viable part of this restructured delivery system administration are willing to work with you to make sure it happens.

In order to make that possible, however, we need Congress to do more than just set the budget number. We need you to establish a reasonable Federal legislative framework and we are not calling for a bureaucracy. We are calling for the kind of framework that

allows you to be a prudent buyer like you could be in the private sector and that does not overburden the States with regulations but yet at the same time ensures that the intent of the legislation is carried out and protects vulnerable members of our communities.

Thank you.

[The prepared statement of Gail Warden follows:]

PREPARED STATEMENT OF GAIL WARDEN ON BEHALF OF THE AMERICAN HOSPITAL ASSOCIATION

Mr. Chairman, I am Gail Warden, president of the Henry Ford Health System in Detroit. We are a comprehensive health system, offering a network of health prevention, diagnosis, treatment, research, education and home health services. Hospital services are offered through our Wyandotte, Grosse Pointe, and Detroit community hospitals, including the 900-bed Henry Ford Hospital in Detroit's inner city. Physician care at all our facilities—including 32 ambulatory care centers—is provided through our Henry Ford Medical Group, one of the nation's largest group practices, with 1,000 employed physicians.

I am also chairman of the board of trustees of the American Hospital Association (AHA), and am pleased to be here today to testify on behalf of AHA's 5,000 hospitals, health systems, networks, and other providers of care.

We are grateful for the opportunity to share the insights and expertise of our diverse membership on the questions surrounding the future of Medicaid. In many communities, hospital-sponsored urban and rural clinics have become the family doctor for the medically underserved, including Medicaid recipients, who would otherwise lack access to primary health care. Regular physician services are often not available in these areas because of the fear of malpractice suits and because of low Medicaid payment rates. These primary care shortages mean that hospitals also see Medicaid beneficiaries and the uninsured in our emergency departments—for conditions that could have been treated much less expensively if caught earlier—and as inpatients.

We are pleased to share our experience in delivering care more cost-effectively to Medicaid recipients, as well as our firm belief in the importance of maintaining that care—for the health of individual beneficiaries, as well as for the health of the larger community.

From our perspective, the current Medicaid debate needs to be put in the context of striking a careful balance. On one side is the legitimate need to moderate rising Medicaid costs. For many states, Medicaid accounts for the greatest share of state spending, averaging 20 percent of state budgets. We recognize that such growing budget commitments must be addressed.

On the other side, however, is our responsibility as health care providers and as citizens to maintain values that led to the establishment of Medicaid in the first place. Society has high expectations for health care. When people are sick or injured, they expect compassionate and competent care. They don't expect to lose their access to care because the financial health of our institution doesn't allow it. And for Medicaid specifically, society expects tax dollars to be spent prudently and effectively, with good results for the neediest members of our communities.

I am here to share our ideas on how best to deliver health care to low-income women and children, elderly, and disabled—those served by Medicaid—in today's constrained budget environment. I am not here today to debate the size of the proposed reductions to the federal Medicaid baseline—even though we continue to have grave reservations about the size of those reductions.

We acknowledge that this committee has a budget target to meet and we want to contribute our share to that effort. But, with fiscal constraints as a given, we also must be able to continue to meet the health care needs of our communities. We believe that, for Medicaid, a careful federal framework is called for—a framework that does not have to be overly burdensome to the states.

There are two major points I want to make today:

First, we must never lose sight of the humanity of the people served by Medicaid. *The greatest proportion of Medicaid recipients are children.* They deserve the opportunity for good health—so they can have the best possible chance to reach their full potential as citizens. We cannot expect them to grow up and become productive workers and parents of the next generation if their basic health needs are neglected.

The greatest share of Medicaid dollars go to the poor disabled and elderly. Many of them have been members of the middle class, but have simply run out

of their own resources. For these recipients, Medicaid quite literally means the difference between having to choose between shelter and food on one hand, and heart medicine or insulin on the other.

Second, reasonable federal safeguards should be built into any changes Congress proposes for Medicaid. Medicaid can be more efficient—but there are limits to the savings. This is true partly because Medicaid in state after state has been chronically underfunded. And there are limits because elderly and disabled patients come to us with complex—and therefore often costly—health care needs.

As this committee contemplates sending federal tax dollars to the states with more flexibility for delivering Medicaid services, we believe it would only be prudent to attach some basic federal conditions to those dollars—conditions that would not, however, call for complex compliance procedures or give rise to a new bureaucracy. (We already have too much Medicaid bureaucracy—in Michigan, for example, there are more than 25 eligibility categories.) Nor would these simple federal accountability standards get in the way of innovative health care restructuring. What they must do, however, is fulfill a fundamental congressional responsibility for the use of federal tax dollars, collected from all U.S. taxpayers to support our shared responsibility to the neediest members of our society.

In the business world, such conditions would be characterized as basic contractual obligations. On behalf of America's taxpayers, it is simply being a "prudent buyer"—of saying, "We are giving you, the states, this significant amount of money to care for the poor, the disabled, and the elderly. In return, taxpayers expect you to give a public accounting of what you do with the money. Is it being spent efficiently, with a minimum spent on administration? Is it going to the purposes for which it is designated? Are the programs it is supporting effective?"

These, then, are the main points for my testimony today—the human faces of Medicaid, and the need for minimum federal Medicaid accountability standards.

WHO IS SERVED BY MEDICAID?

Medicaid is often thought of as health care for poor women and children. But 67 percent of the program's funds actually go to the disabled and the elderly. While poor women and children do make up roughly two-thirds of program beneficiaries, their relatively good health means they consume only one-third (33 percent) of overall costs. The blind and disabled account for 39 percent of funds, and the elderly account for about 28 percent of program costs, largely for nursing home care.

The Medicaid program today plays a significant role in providing health care to the growing number of the uninsured. A number of Medicaid beneficiaries are family members of the working poor, whose jobs do not provide health insurance, and whose marginal salaries do not allow them to purchase private insurance. Today, Medicaid pays the health bills for one of every four children—since children are the most impoverished segment of our population—and covers more than half of nursing home costs. Given its reach, it is clear that major Medicaid changes—changes that will necessarily flow from taking $182 billion out of the federal baseline of the program and billions more in state matching dollars—need to be made carefully. This doubling effect will create painful disruptions for individuals, for the health care system, and for communities. (Many Medicaid beneficiaries and their communities will also be affected by proposed reductions in Medicare.)

Precipitously cutting the strings of the health care safety net would not only have a broad negative impact on individuals and families—it could also have an impact on total health care costs. Medicaid support often allows individuals to live independently, rather than in an institution. It allows family members of Medicaid beneficiaries to continue to work, rather than be tied down by the health needs of a disabled family member. It may even allow the disabled person to work.

The following case histories, drawn from the files of hospital and health systems across the country, illustrate typical Medicaid beneficiaries—many in innovative programs that are already stretching resources further—and the likely impact on their lives of reduced Medicaid support.

A hospital in rural New York notes: "Three essential components of cost-effective health care are prevention, access, and treatment compliance. Our Medicaid MOMS prenatal class has resulted in minimal newborn complications, eliminating the need for very expensive neonatal intensive care services. We operate six outreach primary care centers, four of which are staffed by nurse practitioners or physicians assistants. Any weakening of the Medicaid program would result in a less healthy community with a resulting

increase in costly emergency and inpatient services—and an increased tax burden."

A Kansas City hospital describes some of the Medicaid recipients it serves: "Andrew was born without a pulmonary artery. At five months, he had surgery, and now at age three, is scheduled for additional surgery. Even though he has a low level of endurance—he still needs daily breathing treatments in the winter—he can go out and play. Without Medicaid, his mother, who works to support two older children as well as Andrew, would not have been able to go back to work."

And, also from Kansas: Gary, 32 years old, was born with cerebral palsy, is mildly retarded and confined to a wheelchair. Nevertheless, every workday he gets up in the morning and takes a bus to work at a sheltered workshop. At night, he returns to the apartment he shares with a roommate. His Medicaid benefits cover a personal care attendant who helps with shopping and cooking. Without this help, Gary would not be able to live as independently as he does.

In Michigan, my own Henry Ford Health System is taking part in a federal demonstration project called the "Program for All-inclusive Care for the Elderly," or PACE. Fourteen states have PACE programs underway, which are administered with both Medicare and Medicaid waivers. This allows the projects to receive fixed monthly per-person payments, known as "capitated payment," to cover complete care to the frail elderly. Without the program, these elderly beneficiaries would otherwise be cared for in much more expensive nursing home settings.

By providing services from a physician, nurse, social worker, nutritionist and therapist at a day health center, we are able to help the frail elderly live independently in their homes far longer than they would otherwise be able to do. This initiative is a cost-effective model for frail seniors eligible for both Medicaid and Medicare.

These programs and individuals are some of the many faces of Medicaid. They are so varied because Medicaid is a complex program. It provides health care to three distinct groups—low-income women and children, elderly, and disabled—whose needs vary from primary care, to long-term care, to chronic care. And each state has gone about designing programs in different ways. The fundamental changes proposed for Medicaid need to facilitate and reward innovation, but not lose sight of the overall contract with taxpayers, which is to help people who can't help themselves.

This complexity makes restructuring Medicaid a difficult job. Earlier this year, AHA appointed a broad-based task force drawn from our membership to help sort out the basic principles that should guide long-range Medicaid changes in today's era of cost restraint. These principles are grouped under two headings: Federal Standards for Increased State Medicaid Flexibility and Building a Framework for Medicaid Payment Safeguards. The following are the Medicaid principles AHA recommends:

FEDERAL STANDARDS FOR INCREASED STATE MEDICAID FLEXIBILITY

If states are given increased flexibility to define the Medicaid benefit package and set eligibility criteria, as well as set provider payment rates, there must be federal oversight standards in place to assure a reasonable health care program for the nation's vulnerable populations. These standards should include:

A determination of federal financial participation for each state based on annual changes in population and adjustment for inflation, as well as on those additional payments now going to health care institutions providing care to a disproportionately large share of Medicaid beneficiaries. Using these factors will assure that states facing increases in Medicaid beneficiaries due to an economic downturn or other unexpected factors are not adversely affected.

A requirement that states maintain a proportional financial commitment to Medicaid, and that they ensure that program funds are spent on providing health care services to eligible beneficiaries.

Eligibility for Medicaid must be based on income and need, with the eligibility process clearly defined. While states would be allowed flexibility to streamline eligibility, that eligibility should nevertheless reflect such population groups as low-income pregnant women and children, and low-income elderly and disabled—those currently served by the Medicaid program.

States must continue to provide both acute care and long-term care services to Medicaid beneficiaries according to the needs of the population. Resources should be balanced between them.

States should encourage health care innovation, such as "integrated delivery systems"—cooperating groups of local health care providers that knit the delivery system together for patients. Such groups can better coordinate health care services for Medicaid beneficiaries, and deliver care more cost-effectively.

Regular reports from states on progress toward national goals for improving the health status of the Medicaid population, as well as on improved access to services, must be required. Such reports would ensure that the health status of beneficiaries does not slide backwards as the Medicaid program is restructured.

BUILDING A FRAMEWORK FOR MEDICAID PAYMENT SAFEGUARDS

Congress has had a long-standing commitment to ensuring access to quality health services for the low-income populations served by the Medicaid program. The payment safeguard known as the Boren Amendment has been an important tool in moving toward that goal. If the Boren Amendment is to be changed, we would propose a new framework, drawn from the objectives of the original Boren Amendment, that will help assure access for Medicaid beneficiaries as the health care system undergoes restructuring toward more efficient and cost-effective care. This framework provides an open public process for establishing provider payment rates, including an enforcement mechanism.

The framework for safeguarding payment—and therefore beneficiary access to health services—should include:

A public hearing and comment process for establishing payment rates for providers and for health plans.

Use of an independent actuary to certify that rates are reasonable and adequate to assure access to quality services.

State assurance to the Secretary of Health and Human Services that public process and payment rate adequacy standards have been met.

Legal standing for health care providers to sue if they believe rates are inadequate to provide quality services.

Public disclosure by health plans of rates paid providers, along with an explanation of why rates are reasonable and adequate for providers to assure reasonable beneficiary access to health care services.

We believe these principles provide a reasonable framework under which states could have increased flexibility in designing their Medicaid programs—and which also safeguards beneficiaries' access to quality health care services. Many hospitals and health systems are already voluntarily providing more cost-effective coordinated care for Medicaid beneficiaries. My own system, under HMO arrangements, saves a *minimum* of 10 percent compared to fee-for-service care.

CONCLUSION

I am proud of the role hospitals and health systems play as health care innovators and good citizens. We are important economic anchors—as major employers and participants in the local economy, we provide value for our communities that goes far beyond the health services we provide. This is particularly true for inner-city neighborhoods and in rural areas. And we are important community anchors. For example, Henry Ford Health System is working to address the social problems that contribute to poor health in our communities. We participate in a housing program, a school-to-work program, and in economic development projects.

Hospitals and health systems understand that the world is changing—both our immediate health care markets, and the larger federal and state economic environments in which we operate. We are not resisting, but meeting, these changes with courage and commitment. With our goal of delivering coordinated care through cooperating groups of local health care providers, we have a clear vision for a sustainable health care delivery system for the next century.

We believe the Medicaid program should be a viable part of this restructured delivery system, and are willing to work hard to make sure that happens. In order to make that possible, however, we need Congress to do more than set a budget number. We need you to establish a reasonable federal legislative framework—one that does not overburden states with regulations—to ensure that together we can continue to meet our obligation for serving the health care needs of the most vulnerable members of our communities.

Mr. COBURN. Thank you, Mr. Warden.

Mr. Brown, if you would, please.

STATEMENT OF EDWIN W. BROWN

Mr. BROWN. Thank you, Mr. Chairman.

My name is Edwin Brown. I am the chief executive officer of Florida Community Health Centers, Incorporated, which is an eight-site health center network based in West Palm Beach, Florida. I have local sites located all around Lake Okeechobee serving about 40,000 under-served Floridians including working poor, migrant and farm workers.

I appreciate the opportunity to speak with you today as you consider options for reforming the Medicaid program. I am here today at the request of the National Association of Community Health Centers which represents community-based health centers across America. NACHC has developed a written statement which I would ask you to accept as part of the written record of today's hearing.

As NACHC notes in its statement, America's community health centers were established to serve medically under-served Americans who live in isolated rural communities and economically depressed inner city neighborhoods with too few available providers of care and high rates of serious, preventable or treatable health problems. More than 2,200 local health center service sites across the country are today the family doctor and health care home for almost 9 million people, including more than 3.5 million Medicaid recipients. That is 1 out of every 10 people covered by Medicaid nationally.

Nearly half of our health center patients are completely uninsured and only 14 percent have private insurance. Health center patients are predominantly members of low-income working families, most of whom have little else in the way of available health care. Even those who do have insurance coverage have few other health care choices because of where they live, who they are, and their frequently far greater levels of complex health care needs.

Health centers are locally community-owned and operated nonprofit organizations that furnish comprehensive primary health care to their patients' needs. They are one of the best health care and taxpayer bargains anywhere with a total service cost of less than $300 annually per person that we serve.

Health centers provide continuous care to their patients regardless of the changes in their insurance coverage or status. Their doors are open to everyone in the service area. Uninsured patients pay for care on an income-related sliding fee scale.

While Medicaid payments to health centers are a tiny part of our total Medicaid spending, it is only 1 percent currently, Medicaid revenues are a significant part of the health centers' budgets averaging one-third of the total revenues.

We clearly recognize the difficult task you face in meeting the budget's proposed Medicaid spending caps without causing serious disruptions in the availability of vital health care services for low-income Americans and potentially others, including those who are privately insured.

One much-discussed way of doing so is by encouraging States to make greater use of the managed care for Medicaid recipients. But while managed care can increase access to good quality care and reduce unnecessary or inappropriate services, it can also result in serious problems. The promises and pitfalls, I like to call it.

If its expanded use is poorly designed and are not appropriately monitored, you will have a pitfall. This, in turn, could cause great harm to Medicaid recipients, to providers at health centers who care for those Medicaid patients and for the uninsured low-income people and certainly for the States as well.

While many managed care plans have held down costs, at the same time have improved access to care, which are the promises, other managed care organizations have not. You probably have read recently of some of the problems we are having in Florida. I know the Sun Sentinel out of Ft. Lauderdale did quite an expose on some of the HMO problems. I won't bore you with all the details and anecdotal things, in the interests of time, that I have although there have been many, many cases that I have personally been involved with where patients have been either lied to or they have misrepresented in marketing practices. Just 2 weeks ago I had a woman come to one of my centers with a child with a 104 temperature and come to find that the patient was an HMO and she didn't even know it. She had never signed anything, although they had a card with her signature on it, and she is certainly looking at legal action at this point. But those are the kind of things that are happening throughout with the bad managed care systems.

As you know, our State Medicaid program has encouraged voluntary managed care enrollment for our Medicaid recipients. Over the past 2 to 3 years with about 30 percent of the State's 1.8 million Medicaid recipients are enrolled in managed care plans now.

One of the best safeguards that can be built into managed care and one that promotes quality as well is to take steps to emphasize access to cost-effective preventive and primary health care services which could yield big savings on specialty and inpatient care costs. There are two basic ways to do this: Through the use of strict standards or extensive regulation to measure and monitor access to care together with sanctions for noncompliance or, the one that I like, by providing direct support for the development and maintenance of primary care access points in under-served communities linked with managed care plans.

Taking the latter approach makes policy sense for a number of reasons. It accomplishes your goal of containing costs while at the same time making care much more accessible. And it targets its efforts exactly where they are most needed while doing so in a much less regulatory fashion.

The key principle for what Mr. Bilirakis in his bill, H.R. 3573, the Community Health Improvement Act which he introduced in the last Congress, that was the key principle of what I was just discussing.

In the context of Medicaid 1995, this could be accomplished for example by setting aside a percentage of each State's Medicaid acute care allocation to be spent in supporting the development and maintenance of comprehensive primary health care networks with health centers and other key community providers and, where there are no networks, individual primary care providers such as health centers in under-served communities. Numerous expert studies and reports show that health centers have significantly improved the health of their patients and provide care in a highly cost-effective fashion, including lower hospital admission rates, less

inappropriate use of emergency room services, higher childhood immunization rates and better use of preventive health services such as Pap smears, prenatal care and mammograms which result in lower and preventable illnesses.

Despite the poor overall health of their patients, studies have shown that health centers are tremendously effective in reducing total Medicaid spending, producing on average 30 percent lower cost per case for Medicaid recipients with their patients.

We want to continue to work in partnership with you and with the States to provide cost-effective primary and preventive care and to yield savings for the health care system. Like everyone else, we recognize clearly the need to get health care spending under control and we are willing to do our share but everyone shares in that responsibility and achieving responsible cost containment will require everyone's involvement and contribution on a systemwide basis. To do otherwise is to invite chaos with unexpected and unintended consequences and everyone will pay the price for this as well.

I thank you for this opportunity and I would be happy to answer any questions.

[The prepared statement of Edwin W. Brown follows:]

PREPARED STATEMENT OF EDWIN W. BROWN ON BEHALF OF THE NATIONAL ASSOCIATION OF COMMUNITY HEALTH CENTERS, INC.

Mr. Chairman and Members of the Subcommittee: The National Association of Community Health Centers (NACHC) is the national membership organization of over 850 community-based health centers. We are pleased to submit this statement on behalf of our member health centers on issues related to the future of Medicaid.

America's Health Centers: Quality Health Care Providers for Underserved Americans

America's community health centers were established to serve medically underserved Americans, who live in isolated rural communities and economically depressed inner city neighborhoods with too few available providers of care and high rates of serious, preventable or treatable health problems. More than 2,200 local health center service sites across the country *are today the family doctor and health care home for almost 9 million people, including more than 3.5 million Medicaid recipients*—1 out of every 10 people covered by Medicaid nationally. Nearly half of health center patients are completely uninsured, and only 14% have private insurance. Health center patients are predominantly members of low income working families, most of whom have little else in the way of available health care. Even those who do have insurance coverage have few other health care choices because of where they live, who they are, and their frequently far greater levels of complex health care needs.

Health centers are local community-owned and operated businesses—professional health care organizations furnishing a comprehensive range of primary health care focused on meeting their patients' needs. They are one of the best health care and taxpayer bargains anywhere. The current federal grant cost for each patient cared for by health centers is less than $100 annually; and the total cost of health center services amounts to less than $300 annually per person served.

Health centers provide continuous care to their patients, regardless of changes in their insurance coverage or status. Their doors are open to everyone in their service area. Uninsured patients pay for care on an income-related sliding scale. While total Medicaid payments to health centers constitute a tiny portion of total Medicaid expenditures—an estimated one percent of federal Medicaid spending this year, Medicaid revenues are a significant part of health center budgets, averaging one-third of health center revenues.

Medicaid Managed Care and Underserved Communities

Health centers clearly recognize the exceedingly difficult task facing this Subcommittee—and indeed the entire Congress: meeting the 1996 budget's proposed Medicaid spending caps without causing serious disruptions in the availability of vital health care services for low income Americans—and potentially for others, including those who are privately insured. Even those states, such as Arizona, that have successfully held down Medicaid spending growth through extensive use of

cost-saving managed care, have experienced annual growth rates almost twice as high as the proposed out-year Medicaid spending caps. The same is true of employers and commercial insurers who have implemented aggressive cost containment efforts. Thus, the grave danger is that, in order to meet the spending caps, many states may find it necessary to eliminate services, deny coverage to some who would otherwise qualify, or reduce their already low payment rates to providers. If you also act to remove many of the current-law restrictions on the use of managed care by state agencies, the combination of regulatory relief and spending restrictions is likely to encourage states to dramatically expand the use of managed care for Medicaid recipients.

In the case of Medicaid, managed care has the potential to do either great good or great harm. Under the right circumstances, managed care can significantly increase Medicaid beneficiaries' access to good quality care, to provide a medical "home" that stresses early and timely entry to preventive and primary care services, and to reduce the provision of unnecessary or inappropriate care. However, if such arrangements are underfinanced, poorly designed or not appropriately monitored, managed care programs—especially those involving risk arrangements and/or mandated enrollment of beneficiaries—could yield serious, negative health and economic consequences for the millions of people who today depend on Medicaid coverage, for those providers who serve significant numbers of both Medicaid-covered and uninsured low income women and children, and for states as well.

While the original models of managed care (including health centers and early Health Maintenance Organizations) have succeeded in achieving both improved access to care and cost containment by emphasizing the availability and accessibility of primary care, some more recent managed care organizations have been found to achieve cost containment in no small part by making their care inaccessible, especially primary health care services. Without adequate checks and balances, some current financing, mechanisms, most notably the rapidly-expanding use of risk-based capitation payments, can actually lead to promoting, encouraging, and rewarding such organizational behaviors; yet there currently exist no recognized mechanisms to ensure adequate health care access, especially to preventive and primary health care services.

Thus, even with health system restructuring, most urban and rural communities with large low income populations remain vulnerable to two basic health care access problems. The first is a complete lack of services in communities that cannot afford to attract and maintain health care providers of good quality. The second is the development of large numbers of underfinanced prepaid health plans that ultimately are forced to depend on systemic under-service for their economic survival.

Ways to Address The Problem of Underservice

We are not here to say that savings cannot be achieved in Medicaid. Rather, we wish to stress the importance of focusing on *how* any savings are to be achieved. One way to do so would be to use health care systems that emphasize access to cost-effective preventive and primary health care services, which could yield big savings in specialty and impatient care costs. One of the best safeguards that can be built into managed care (and one that promotes quality, as well) is to include mechanisms that promote primary care utilization and to assure its accessibility and availability to a community and its residents. Most notably, financing mechanisms are needed which reward primary care accessibility and discourage the creation or use of barriers to such care.

There are two basic ways of achieving this objective: One is through the use of strict standards, or extensive regulation, to measure the adequacy of access to primary and other services, together with sanctions for failure to meet the standards; Another way is to provide direct support for the development and maintenance of primary care access points in underserved communities, linked with the managed care plans.

Taking the latter approach makes policy sense for a number of reasons. By definition, underserved people and communities already lack access to important health services, suffer from an acute shortage of providers, and experience some of the worst health statistics recorded anywhere. In many of these communities, health centers are the only primary care providers available to low income families, especially those who are uninsured or are covered by Medicaid. But in far too many underserved communities, there are no health centers, nor any other accessible primary care providers.

If restructuring is to succeed—particularly in achieving its goal of cost containment—access problems in underserved areas must be ameliorated, not exacerbated. This is especially true for preventive and primary care services: care that is so crucial to improving and maintaining health and to containing costs. Moreover, such

an approach would target its efforts exactly where they are most needed, while doing so in a much less regulatory fashion. This is the key principle, Mr. Chairman, that gave rise to the concept proposed in H.R. 3573, the Community Health Improvement Act, which you introduced in the last Congress.

This objective can be accomplished, for example, by setting aside a percentage of each state's Medicaid allocation for acute care services to be spent in supporting the development and maintenance of comprehensive primary health care networks and (where no networks exist) community-responsive primary care providers (such as health centers) in underserved communities.

Development of primary and preventive care in underserved communities has been shown to be particularly effective in reducing unnecessary and inappropriate use of other settings such as emergency rooms, which are much more costly. Moreover, such efforts have yielded significant reductions in overall health care costs. This is especially true of public-private partnerships such as the federally-assisted health center programs. Numerous expert studies and reports show that health centers have significantly improved the health of their patients and provide care in a highly cost-effective fashion, including lower hospital admission rates, less inappropriate use of emergency room services, higher childhood immunization rates, and better use of preventive health services (like Pap smears and prenatal care), resulting in lower rates of preventable illness.

Because of their experience, the health centers—together with other key community providers form the backbone of the local health care system for most underserved people and communities, and have had a major impact on the health of their communities:

- Their presence and availability of services has significantly lowered unnecessary use of costlier, less appropriate settings such as hospital emergency rooms and "Medicaid mills".
- Their consolidation of both preventive and comprehensive primary care services under one roof has measurably reduced the frequency and cost of preventable illnesses.
- Their experience in case management has brought about a substantial reduction in specialty care and hospital admissions, saving millions of dollars for the health care system.
- Their patients are exceedingly pleased with the care they receive, according to a recent nationwide survey, and thus make appropriate use of the preventive care they offer.

Despite the poorer overall health of their patients, studies have shown that health centers are tremendously effective in reducing total Medicaid spending, producing *on average 30% lower costs* per case for Medicaid recipients who were their regular patients than for Medicaid recipients who used other providers such as private physicians, group practices, hospital emergency rooms, or even HMOs. Health centers have achieved such success because they are managers of care, keeping their patients healthy and reducing the inappropriate use of costly emergency room, specialty, and inpatient hospital services. They are also experienced in the management of health care costs, since they must run their programs within very limited annual budgets.

Health centers clearly recognize the changes that are sweeping across the country's health care system, and are aggressively moving to be part of the evolving health care system. In states and communities across the country, health centers have taken steps to form networks and even full managed care plans with other local providers, to negotiate subcontracts with other managed care plans, and to develop the financial, legal and business acumen necessary to function effectively in the new climate.

Thus, setting aside funds to support primary care networks in underserved communities, and linking those networks with managed care plans can work. And, if done right, such efforts could yield substantial savings, at least in the roughly one half of Medicaid spending that goes for acute care services for children and adults, including the aged and disabled. If, on the other hand, some managed care systems are able to make entry level care less accessible, then it is possible—and even likely—that many people will remain outside of the health care system until their health problems become so serious that they require extensive and costly care, or else they will resort once again to seeking care at inappropriate locations like hospital emergency rooms, and the costs will fall to someone else to pay. But most private payers are also engaged in aggressive efforts to control their health care costs, thus making it increasingly difficult for other providers to continue offering care to those without coverage, or whose plan will not authorize payment for such care. If that happens, millions of Medicaid-covered and uninsured people may find that the

only providers available to care for them are the health centers and few other safety net providers in their communities. Without adequate resources, however, these providers, who have no place else to shift the costs of their care, will be faced with either terminating essential services, seeing fewer people, not paying their bills, or closing down altogether.

Health centers want to continue to work in partnership with the Federal government, state governments, and local communities to provide cost-effective, high quality primary and preventive care, while at the same time yielding savings for other parts of the health care system. Like everyone else, we recognize clearly the need to get health care spending under control, and we're willing to do our share. But everyone shares in that responsibility, and achieving responsible cost containment will require everyone's involvement and contribution, on a system-wide basis. To do otherwise is to invite chaos, with unexpected and unintended consequences—and everyone will pay the price for that, as well.

Thank you for this opportunity to present our views on this all-important issue. We look forward to working with the members of the Subcommittee to effectively address this and other vital health care matters.

Mr. COBURN. Thank you very much.

I think I will ask questions, since I am the only one here right now.

Let me start with you, Mr. Brown.

Target of the assistance and access in conjunction with managed care, if in fact effective, why wouldn't a State be interested in doing that without a Federal guideline saying you must do that?

Mr. BROWN. We would hope the States would be interested in doing that. With a block grant and the Medicaid waivers that they have received, we are hoping that we will be able to work closely with them and, as a matter of fact, in the State of Florida and many other States, there have been many of us who have been putting together some PHP plans or some plans to work directly, contract directly with the Medicaid programs to allow us to provide and expand our comprehensive primary care access points.

Mr. COBURN. So it is your feeling then that the motivation of a State under a block grant proposal from the Federal Government for Medicaid was, No. 1, that you have to cover and there are minimal guidelines of what you have to cover, that their motivation is to get the coverage most efficiently and they might be able to do that, we think, under-served directed access managed by managed care?

Mr. BROWN. We feel they would if there was a set-aside in the acute care, as I mentioned, that we could use to develop and expand on our services.

Mr. COBURN. What about without a set-aside? This is the point I am having trouble understanding is if a State is charged, this is your responsibility and we are going to measure to see you do what you are supposed to do and here is a minimal requirement that you have to meet, whether it's MR waivers or whatever, if that is what it is, then it would seem to me that if this is a very efficient way of doing it and targeting under-served areas, that they are going to do it without a set-aside.

Are you saying that they probably won't without a set-aside?

Mr. BROWN. What I am saying is that the money may not stretch far enough to be able to allow that, especially in Florida, as you heard from Governor Chiles's testimony. With the growth rate in the Medicaid recipients in Florida compared to the amount of increase of Medicaid money that will come to Florida, we are going to be behind.

Mr. COBURN. Right, but it is important for us not to confuse those two issues. One is whether or not you can achieve it; the other has to do with the reimbursement by State issue that is way out of whack in this country anyway and that becomes a political issue.

Let me ask it another way. If we could solve the reimbursement problem to where it was truly fair and equitable everywhere, what would your answer be to my question? If it was an equitable——

Mr. BROWN. If it were an equitable system, I would say yes.

Mr. COBURN. Because they really are two problems and I don't want us to concentrate on that problem right now. We all know it and we need to solve it and it is going to be a very difficult problem to solve and probably the outcome of whether or not we block grant will be on whether or not we have a successful resolution to that problem.

My State, Oklahoma, gets about one-fourth as much as the State of New York per Medicaid patient. So there are some big differences there.

Ms. Hantzes, I want to just ask you a question. I am a family practice physician and deliver babies and I have about six children in my practice with severe—whether it is aneurism or lissencephaly or other problems that have been severe and I don't have one of those patients that is on a waiver.

Now, they are very, very fortunate people.

Ms. HANTZES. Have them call me.

Mr. COBURN. Have them call you? Okay, I will.

My question to you is, if Medicaid were block granted with requirements that say, these are some services that we think you have to demonstrate that you are going to offer, would you be objectionable to block granting if, in fact, that is part of the conditions for the block granting? In other words, the service that is available to you on a waiver basis now, if that were a portion of that, of the block grant mechanism——

Ms. HANTZES. If it were a requirement?

Mr. COBURN. If it were a requirement that they meet those needs, would you object to the fact that your State might better be able to handle Medicaid than we can here?

Ms. HANTZES. No. If it were a minimal requirement that these needs be met, I think I would feel comfortable with that.

Mr. COBURN. Okay. Okay.

Ms. HANTZES. But I think without it——

Mr. COBURN. I understand. And that leads me to my second question. I understand your situation because I can identify with it with my own patients but it seems to me we tend to believe only the Federal Government cares and, you know, I know for a fact that that is not the case. The Federal Government is the only one who can spend money it doesn't have so therefore it is a lot easier to care.

Help me with your feelings about your State and why your State didn't participate in that initially.

Ms. HANTZES. I happen to live in a State where the Governor said he thinks one of the best ways to help retarded children is to get a group of people together and mow the lawn and trim the hedges at the institution.

Mr. COBURN. Okay, thanks. Good answer.

I have a couple—Mark, I would like to visit with you if I can.

Mr. BARNES. Yes, sir.

Mr. COBURN. One of the statements that you said is that adequate Medicaid coverage in the AIDS population reduces cost. Do you have a study that shows that or is that what people feel or think or is there a study out there that I am not aware of that shows that?

Mr. BARNES. Well, yes, sir, I believe there is a study and I could work with you to get that to you. The most generous Medicaid package at a State level is in New York State where there were some rates that were crafted about 6 or 7 years ago that provided a very high reimbursement on the outpatient side to encourage hospitals to take care of people. And what they have done is they actually have done several cost efficiency analyses of that and they have found what that has done in effect is reduced inpatient hospitalization and they think that it is traceable to two things. One is the enhanced Medicaid rate structure to encourage outpatient providers to come into the system and second is the impact of the Ryan White money in providing outpatient care.

Mr. COBURN. So following the same thing we know in other enhanced outpatient care, we are going to save money.

At St. Vincent's, what percentage of the costs at that clinic are covered by Medicaid, do you know?

Mr. BARNES. There, about $2 million in Medicaid revenue that goes into that clinic and into that you would add about—and I have the exact figures; I got them for this testimony. You add about $1.5 million in either State or Federal grants and some of that would be Ryan White money but not all of it is Ryan White money. And into that you add about another $1.5 million in private grants from the community trust from pharmaceutical companies to do clinical trials there which includes some money for primary care people within the clinical trials and then also some significant money from the American Foundation for AIDS research, which is all private money.

Mr. COBURN. So close to 40 percent of the funding for that?

Mr. BARNES. Yes, sir.

Mr. COBURN. I just want to confirm one other thing that you said. Every AIDS patient that I have ever cared for, which has been a significant number, eventually utilized Medicaid. Every one. And so I think your testimony is right on in terms of making sure that that funding is there.

Let me ask one followup question to that and then I will allow each of you if you want a couple extra comments into the record and then we will break for lunch.

Is it your feeling that if we had the proper guidelines on block granting that we could in fact offer the services that are needed for those that are positive with HIV under a Medicaid block grant?

Mr. BARNES. Well, I think that the answer is two-fold. One is that we would have to craft the corporate minimum standards and I take that as a presumption of your question. But the other part of a block grant, though is exactly what that is going to mean in terms of the funding level. Because what we have in HIV and it is somewhat different than other populations. It would be more

akin to, for example, the populations of people with tuberculosis. But we have a growing epidemic so in that case what I would want to see in the block grant, what we would want to see in the block grant if that is the way that Congress chooses to go, is that there be adequate money in there to take care of growing case loads. And I think if there were adequate money and the adequate money would thus, you know, mean that there would continue to be, at least at the State level, the entitlement to services that the money would be growing with the case load and if there were appropriate minimum standards, then there might be some helpful ways that States might craft, for example, outpatient services and some community and home-based services that might take better care, even, of people with HIV. But it would have to be very carefully done and with the adequate money.

Mr. COBURN. I find I have listened to several of the different panels on the different days that we have had on Medicaid and the thing that seems to ring through which really bothers me, this is my seventh month in Congress, is we always get to hear more about what doesn't work than what does and it just seems to me that we need to make sure that we don't lose sight of the fact, you know, being very discerning about problems is one thing but lack of discernment about positive results is something that will cost us great opportunity in this country and I appreciate each of your testimony.

I would like to give anybody who would like to say or add anything additional to the record time to do that now.

Mr. Warden, would you like to do that? And then we will break for lunch until 1:30.

Mr. WARDEN. Yes, Mr. Chairman.

I think it is important to emphasize that a lot of organizations are not opposed to the block grant concept, they are certainly opposed to unfettered block grants. I don't think they are against giving flexibility to the States but they do want to make sure that in this transition that that flexibility and the change takes place, that there is accountability and public reporting built into it and protection for the kinds of populations you have heard about here today.

Mr. COBURN. What I would just tell you as one Member of Congress in the majority right now and as a physician, I have no interest in writing a blank check for States for health care without making sure that the proper guidelines and expectations of that money is carried out. So I thank you and I think I can speak for several other of the freshmen that have that same feeling.

I want to thank each of you for being here. We will adjourn until 1:30 when Chairman Bilirakis will bring on the next panel.

Thank you very much.

[Whereupon, at 12:49 p.m., the luncheon recess was taken.]

AFTERNOON SESSION

Mr. BILIRAKIS. This afternoon session will come to order.

Panel IV consists of Mr. Stephen McConnell, substituting for Mrs. Edna Faris. He is representing the Alzheimer's Association. Ms. Judy Waxman, Director of Government Affairs, Families USA here in Washington; Dr. Paul Willging, Executive Vice President of American Health Care Association, Ms. Beatrice Braun, Board

Member, American Association of Retired Persons (AARP); Ms. Ceilia Wcislo, President, Local 285 of Service Employees International Union; Ms. Kathleen Gannoe and last and not least, being transferred from Panel V because he has to leave early, is the Honorable Albert Eisenberg, Supervisor of Arlington County, Virginia, representing the National Association of Counties.

As per usual, your written statement is a part of the record. I would appreciate if you could keep as close to the 5 minute rule as you possibly can and we will start off with Mr. McConnell.

STATEMENTS OF STEPHEN McCONNELL, SENIOR VICE PRESIDENT FOR PUBLIC POLICY, ALZHEIMER'S ASSOCIATION; JUDY WAXMAN, DIRECTOR, GOVERNMENT AFFAIRS, FAMILIES USA; PAUL WILLGING, EXECUTIVE VICE PRESIDENT, AMERICAN HEALTH CARE ASSOCIATION; BEATRICE BRAUN, BOARD MEMBER, AMERICAN ASSOCIATION OF RETIRED PERSONS; CELIA WCISLO, PRESIDENT, LOCAL 285, SERVICE EMPLOYEES INTERNATIONAL UNION; KATHLEEN GANNOE, VICE PRESIDENT, NATIONAL CITIZENS' COALITION FOR NURSING HOME REFORM; AND ALBERT EISENBERG, ON BEHALF OF NATIONAL ASSOCIATION OF COUNTIES

Mr. McCONNELL. Thank you, Mr. Chairman.

I appreciate your inviting the Alzheimer's Association to testify today on behalf of the 4 million people with Alzheimer's and their families and I also particularly appreciate your interest and concern for people with Alzheimer's and Parkinson's Disease.

I wasn't supposed to be here today, as you know. The Alzheimer's Association is made up of chapters, families and volunteers from across the country and when asked to testify we like to have people who can tell their own stories rather than hearing from people like us, from within the beltway.

We appreciate your willingness to have Mrs. Edna Faris testify. Unfortunately, she had surgery in the past week and did not recover and the doctors would not let her testify but her story is important because it shows that Medicaid is about ordinary people who spent their lives doing everything right.

Her husband, Moose, was a Naval officer, a science teacher and a football coach in the Fairfax County schools. In 1990, Moose got Alzheimer's Disease. Edna took care of him for 3 years and by the time the doctors insisted he go to a nursing home, they had almost nothing left. They were eligible for Medicaid but under Virginia spousal impoverishment rules, Edna receives less than half of Moose's monthly Social Security and pension check. The rest, $1,500 a month, goes to pay the nursing home bill and Medicaid pays the balance.

I can't begin to tell Mrs. Faris's story but I would like to read just the final part of her prepared testimony. She says:

"I believe if Medicaid is cut, my husband could become ineligible for services or services for him would be severely limited. I say to you, I couldn't face worrying every year about whether his care will be paid for. It sounds like the lottery to me and I don't have anything more that I can risk."

Well, Medicaid pays for long-term care for 4 million Americans, people who have exhausted their resources and, of course, two-thirds of these are elderly. They are people like Elaine and Stewart Millon from Galesburg, Michigan. Stewart spent 17 years in a small law firm and then 25 years as a pastor. He saved, he raised his children and he got Alzheimer's disease. Elaine cared for him at home but then she got sick so he had to go into a nursing home. They spent everything they had, their life insurance, their IRA's, their savings, down to $17,000 that Michigan law lets them keep and if it were not for Medicaid, she could not have come close to affording the $100 a day that it takes to keep him in that nursing home.

It is also people like Betty and Howard Tidwell from Paducah, Kentucky. Betty was in the WAVES in World War II and then a secretary in a county courthouse. Her husband, Howard, was a farmer, he sold cars, he was a private security guard. Neither of them made much money.

Well, at age 71, Betty is now the full-time care giver for Howard who, at 79, has Alzheimer's Disease, Parkinson's and congestive heart failure. They qualified for Medicaid waiver services, $150 a week of help. They get some day care for 4 hours a couple of days a week and a little bit of home care. The only time that Betty has for uninterrupted sleep, shopping for groceries and taking care of herself is when she is getting help because of these waivered services. With help, Betty is able to keep Howard at home. Without it, both of them would be in a nursing home.

There are many stories like Edna and Moose Faris, Elaine and Stewart Millon and Betty and Howard Tidwell and all of them wanted to be here. All of them had some condition that prevented them from coming and I would encourage you and your colleagues to visit with families like that during the recess. I know you understand what these families are going through and if your colleagues would like help in setting up meetings over the recess, we would be happy to help.

In conclusion, I want to make three recommendations. First of all, don't cut $182 billion from Medicaid. There is no way to do it without harming low-income and frail elderly. States have only so many options to bring spending within the limits that Congress sets. They can cut provider reimbursement, eliminate benefits or cut back on eligibility. Whatever they do, it is beneficiaries who will suffer.

Second, a Medicaid block grant risks essential protections for the most vulnerable elderly. People like Elaine and Stewart Millon will not know whether they will have protection or not unless there is some basic entitlement to help. It also undermines efforts to make managed care work for older people with chronic illnesses because it would shift to the States a program that then has to try to coordinate with the Federal Medicare program and you have heard testimony on that today about the problems that would be created by that.

Finally, we have two recommendations for structural changes in Medicaid that do have real potential for achieving cost savings in ways that do not harm the frail elderly. First, encourage a more balanced long-term care system that places greater emphasis on

home and community care. And, second, encourage coordination and integration of acute and long-term care in managed care systems for the frail elderly. The latter recommendation is as important to the future of Medicare as it is to Medicaid.

In closing, I cannot help but express the frustration I am sure you and many others feel about the narrow focus of today's hearing and the fact that we have to just focus on Medicaid to make budget cuts. We understand that a budget resolution forces you to operate under these circumstances. Unfortunately, some of what Congress may be forced to do is likely to exacerbate problems in the health care system as a whole and real health care cost containment has to come through reforming the entire system and we look forward to getting back to that day at some point.

Thank you.

[The prepared statement of Stephen McConnell follows:]

PREPARED STATEMENT OF STEPHEN MCCONNELL, SENIOR VICE PRESIDENT FOR PUBLIC POLICY, ALZHEIMER'S ASSOCIATION

Mr. Chairman and Members of the Committee. Thank you for inviting me here today to talk with you about the Medicaid program and its vital importance to millions of older Americans. I am here on behalf of the Alzheimer's Association, the national organization that speaks for the 4 million people who are living with Alzheimer's disease and their families who are struggling with the overwhelming costs of care.

Mr. Chairman, you and your colleagues on the Commerce Committee face the unenviable task of trying to find a way to achieve the spending targets set in the budget resolution without devastating programs that guarantee basic health and economic security for very vulnerable people. Nowhere will that task be more difficult than Medicaid. We certainly want to work with you to try to fashion approaches that will address some of the real problems we all recognize in the Medicaid program and move us to realistic cost control, without harming people and exacerbating problems in our health care system.

You have assembled this panel to talk about Medicaid and the elderly. But before doing that, I want to make a broader point. Distinctions among "categories" of Medicaid beneficiaries are arbitrary and potentially dangerous. The elderly need long term care because of their disabilities; people with disabilities are aging; disabling illnesses like Alzheimer's and Parkinson's—generally considered diseases of aging—are striking younger people as well. That is why the Alzheimer's Association has always approached the long term care issue as part of a coalition of aging, disability, and children's organizations that make up the Long Term Care Campaign.

People live in families, not age groups. And everyone in the family is affected by the birth of a child with a disability, a job loss that means the end of health insurance, a wage earner's spinal cord injury, or a grandparent's Alzheimer's disease.

The last thing we should do is set up a situation that forces needy individuals and families to fight with each other over pieces of a shrinking Medicaid pie. That may be the inevitable result of the drastic spending cuts and block grant proposals now on the table.

My testimony will focus on Medicaid as a vital lifeline to long term care, because this is what brings families dealing with Alzheimer's disease into the system.

First, I want to talk about the people that this debate is really all about. Then, I will comment on the implications of the budget resolution. The Alzheimer's Association believes that a $182 billion budget reduction is too drastic, and that converting Medicaid to a block grant is an unwise and dangerous abdication of federal responsibility. We do not see any way you can do this without harming people with Alzheimer's disease and other very vulnerable people. Finally, I will offer our suggestions about what Congress can do to help control the costs of Medicaid long term care while preserving essential supports for families for whom there are no other options.

Medicaid Is the Insurer of Last Resort for 4 Million Americans Facing a Long Term Care Crisis

In 1995, more than one in three Medicaid dollars ($53.5 billion) will pay for long term care, for 4 million people who have exhausted their own resources. Two-thirds of these long term care beneficiaries are elderly. The rest are parents of young chil-

dren with serious disabilities and working age adults who need long term services and supports because of an injury or chronic illness or disability.

Medicaid pays more than half of the total nursing home bill in the United States and helps 6 out of 10 residents. This is because neither Medicare nor private health insurance policies covers the type of "custodial" long term care a person with a chronic illness like Alzheimer's disease needs. Confronted with annual nursing home bills that average $38,000 a year (and are much higher in many urban areas), most middle class families rapidly exhaust their life savings. Increasingly, states are beginning to use Medicaid to help people with serious disabilities live at home or in the community, where care is less costly and where people want to be.

The current Medicaid debate is not just numbers in a budget documents—it is about people.

People like Elaine and Stewart Millon of Galesburg, Michigan. Stewart spent 17 years in a small law practice, then was ordained a Lutheran minister and spent the next 25 years as a pastor. He and Elaine raised their children and saved for their retirement. But Stewart got Alzheimer's disease. Elaine cared for him at home as long as she could, but she became ill. When Stewart finally had to move to a nursing home, Medicare was no help because the kind of care he needed was considered "custodial". Elaine liquidated every asset they had—life insurance, savings, IRAs—and spent it to pay the bills, until she was down to the $17,000 Michigan allows her to keep under spousal impoverishment rules. Now, Elaine spends half of her remaining income on her share of the nursing home bill; Medicaid pays the balance. This leaves her with about $1200 a month to live on. The nursing home now costs $100 a day. Even if Elaine spent every penny she had left, she would not have enough to pay the bill without help from Medicaid.

This debate is also about people like Betty and Howard Tidwell of Paducah, Kentucky, married 35 years ago. Betty was in the WAVES in World War II, then came back to a job in the County Court House, from which she is now retired. Howard started as a farmer, sold cars, and finally worked as a guard for a private security force. Neither of them ever had high paying jobs, but they paid off their mortgage and saved what they could for their retirement. Now, at the age of 71, Betty provides round-the-clock care for Howard, age 79, who has Parkinson's and Alzheimer's disease, diabetes, and congestive heart failure. They live on their combined retirement income of less than $1000 a month. After spending down their savings to spousal impoverishment levels, Howard now qualifies for Medicaid waiver services. That gives them about $150 worth of help a week—Howard goes to a day care center for 4 hours two days a week, and Betty gets help with him at home for another 6-8 hours a week. This is the only time she has for uninterrupted sleep, to shop for groceries and Howard's diapers and medications, or to take care of herself. Betty and Howard do not have children. Their three siblings are all in their 70's and 80's and have their own health problems. With help from Medicaid, Betty is managing enough time to keep herself reasonably healthy and to keep Howard at home. Without these services, Betty says, both she and Howard would quickly end up in a nursing home (with no money to pay the bill).

And it is about Claudia and Harvey Schnaible of Council Bluffs, Iowa. Harvey began exhibiting the symptoms of Alzheimer's disease in his mid-50s. He lost his job as a credit manager, and tried to find work he could still handle. For a while, he worked as a janitor at Creighton University. But eventually, Alzheimer's caught up with him. For the past 7 years, he has lived in a nursing home. After years working in department stores, Claudia had just opened her own small women's clothing store. But she had to give that up when the bills for Harvey's care took everything they had. Within two years, they had used all of their savings to pay over $80,000 in nursing home bills. Now he qualifies for Medicaid. Most of Harvey's social security check—$755 a month—still goes to the nursing home. (Medicaid picks up the balance.) Claudia gets $253 from Harvey's check, under spousal impoverishment rules. She works in a local department store to get enough money to make the house payments, pay for insurance, utilities and food. As she says, she goes from pay day to pay day, never knowing for sure whether there will be enough to make ends meet. Harvey's nursing home now costs over $3000 a month. The Schnaible's have no way to pay that bill without Medicaid.

Mrs. Tidwell, Mrs. Millon, and Mrs. Schnaible all wanted to come here to tell you their stories themselves. But Mrs. Millon has just had knee surgery again. Mrs. Tidwell could not make arrangements for Howard's care, to get away on such short notice. And Mrs. Schnaible is just starting a new job this week. They asked me to invite you to visit them and families like them when you are at home during the August recess, before you make decisions here that will determine the future of Medicaid. The Alzheimer's Association and our Chapters in your Congressional Districts would be happy to help you make those arrangements.

The $182 Billion Cut in Medicaid Spending Is Too Big—It Cannot Be Achieved Without Harming Low Income and Frail Elderly

All of us would like to believe that it would be possible to achieve the savings in the Budget Resolution without harming people. But an honest look at the numbers makes it pretty clear that cannot be done. Under the Budget Resolution, the growth in Medicaid will be capped at 4% after 1998. This would mean that Medicaid spending would be reduced by almost 30% from its current projected level in 2002.

According to an analysis done by the Urban Institute for the Kaiser Commission on the Future of Medicaid, under current law Medicaid expenditures for the elderly will grow an average of 8.9% between 1994 and 2000. If states were to absorb the cuts in the Budget Resolution equally across all eligibility groups, the Urban Institute estimates a reduction of from 429,000 to 928,000 elderly Medicaid beneficiaries who would have been eligible under current law in 2002.

An analysis of the impact on long term care alone, done by Lewin-VHI, paints an even grimmer picture. Looking particularly at the projected growth of home and community based long term care under current law, Lewin estimates that over 2 million elderly and persons with disabilities of all ages could lose their access to long term care. An earlier analysis of the impact of the House Budget Resolution suggested that 13 states (Alabama, Georgia, Hawaii, Indiana, Iowa, Louisiana, Mississippi, Nevada, North Carolina, Ohio, Pennsylvania, Tennessee, and Texas) could be forced to give up their home and community care programs altogether.

States will have only so many options to bring their spending within the limits Congress is attempting to impose. They can cut provider reimbursement. They can eliminate benefits. They can cut back on eligibility. Whatever they do, it is the beneficiaries—the frailest, the sickest, the poorest—who will suffer.

Some hold out the promise of private long term care insurance as the way out of this dilemma. But even the most enthusiastic proponents of this product concede that it will never cover more than 40% of the elderly, primarily because of the cost of a good policy. Some put the number as low as 10%. And because of medical underwriting (a responsible practice insurers use to prevent adverse risk selection), almost no one who already has symptoms that suggest an eventual need for long term care can buy a policy, regardless of their income. Even if the industry is successful in its attempts to market long term care insurance to younger people and can manage to maintain premium stability so that people can afford their policies over time, the impact of that coverage will not be seen until well into the next century as those insured begin to reach the ages where they are most likely to need long term care. Over the next 7 years (the life of the Budget Resolution), most elderly who will need long term care will have no option but to spend their own income and resources until they qualify for Medicaid—if the program is still there to help them.

A Medicaid Block Grant Risks Essential Protections for the Most Vulnerable Elderly.

Everyone in this room knows that Medicaid is not a perfect program. But Congress will not solve the problems in the program by abdicating the federal role and sending the money out to the states in a block grant. It could just make matters worse. Whatever you do to restructure the Medicaid program, there are certain essential protections that must be maintained.

First, and foremost, Congress must *maintain coverage for individuals*. People like Elaine and Stewart Millon, Betty and Howard Tidwell, Claudie and Harvey Schnaible must be assured of one last place to turn for help when they have no other way to meet extraordinary costs of health or long term care. Almost no one can plan adequately for the devastation of a disease like Alzheimer's. Until we are ready as a nation to develop a comprehensive response to the long term care problem, we must maintain Medicaid as a final safety net.

Flexibility is certainly a key to developing cost effective and appropriate quality long term care services and supports for individuals and families whose needs are as varied as the causes of their disabilities. The Alzheimer's Association has long advocated changes in Medicaid law to make it more possible for states to shape programs to meet those needs. But we have also worked with this Committee to build into the program essential protections that must be preserved—including *spousal impoverishment rules and nursing home quality standards.*

If spousal income protections disappear, we are setting the stage to return to the days when retired couples were forced to make horrendous choices when one of them entered a nursing home—either divorce after a lifetime of mutual commitment to protect some income for the spouse left at home, or give up the house and all income security for the spouse to pay the nursing home bill.

Without federal nursing home quality standards, we may see a move back to the time before enactment of the 1987 nursing home reform law, when many states abdicated any responsibility to assure quality. The progress that has been made to re-

store dignity and quality of life for nursing home residents, to end the misuse of physical and chemical restraints, to assure training for nursing home workers, will begin to erode.

The nursing home reform law Congress enacted has lead to better care. It has also brought demonstrable health care savings. A recent evaluation of the resident assessment requirements of the law showed a significant reduction in functional decline of nursing home residents and a 25% reduction in hospitalization.

Finally, Congress must *maintain a federal role in Medicaid* if there is any hope of making managed care work for the elderly. Instead of driving a total wedge between acute and long term care by turning Medicaid into a block grant to the states, Congress should be looking for ways to bring Medicaid and Medicare together—to coordinate services for the elderly across the continuum of care, and perhaps to integrate the program altogether.

Recommendations for Structural Reforms That Can Achieve Cost Savings and Protect Beneficiaries

The Alzheimer's Association has two recommendations for structural changes in Medicaid, specific to long term care, which have real potential for achieving cost savings in the program in ways that do not harm, but in fact benefit the frail elderly who rely on the program:

- First, encourage a balanced long term care system that places greater emphasis on home and community care than Medicaid does today; and
- Second, encourage coordination and integration of acute and long term care in managed care systems for the frail elderly.

Home and Community Based Long Term Care. One of the greatest frustrations of current Medicaid long term care, for both consumers and the states, is the presumption in favor of the nursing home as the preferred setting of care—even though that is usually the most expensive place to receive care and the place the elderly fear most. Over and over again, families tell us that they want to keep their loved ones at home, but it is extraordinarily difficult to do that without help. Current Medicaid law requires puts strict limits on the amount of such services states can offer, and then limits access to persons who are ready to enter a nursing home.

Federal law should encourage a balanced long term care system that includes home and community care, as well as a range of residential care options in addition to nursing homes. (Home and community care includes but is not necessarily limited to personal assistance, respite, adult day care, homemaker and chore assistance and home health, with the transportation and support needed to utilize the services.) This has the potential for real cost savings in Medicaid long term care, for those who can live independently if they have appropriate services, and for those who have family who can care for them at home if they have enough help.

> In the case of a person with Alzheimer's disease, research shows that it is possible to provide care at home at a cost that is three and a half times less than the cost of care in a nursing home—$12,500 compared with $42,000. This is not because the person at home needs less care, but because at home families can continue to provide most of the care, if they have enough help.

Congress should specifically eliminate requirements of current law that tie eligibility for home and community care to nursing home care. To control their long term care expenditures, states are requiring higher levels of functional disability for nursing home care, but under current law, that has the perverse effect of denying home and community care to persons with lesser disability—even though such care could delay and in some cases prevent their eventual need for nursing home care.

> New research shows, for example, that a relatively inexpensive service like respite (the kind of help Betty Tidwell is getting) can significantly delay the need for nursing home care—but only if it is provided early enough in the course of the disease to make a difference. Under current Medicaid law, even respite care is not available until the disease has progressed to the point the person qualifies for a nursing home.

Some might argue that a block grant would remove the federal rules that skew the current Medicaid program toward institutional care. But that does not outweigh the arguments against block grants, nor does it ensure that change will occur. We believe it will take clear federal leadership to overcome the institutional bias in the program.

Making Managed Care Work for the Frail Elderly. Many in Congress are placing great stock in managed care as the way to achieve major cost savings in both Medicare and Medicaid. But managed care is full of risk for people with chronic illnesses like Alzheimer's disease if the driving force is cost. The current division of respon-

sibility for acute and long term care, among payers and providers, already discourages real management of care through the course of the disease.

Today, an Alzheimer patient gets shuffled back and forth between doctors, hospitals, and nursing homes. No one—payer or provider—is responsible for her overall care and well-being. And the system is full of incentives to shift the cost of her care to someone else. That will only get worse if, on the one hand, Congress pushes Medicare beneficiaries into managed care while, on the other hand, it severs its responsibility for Medicaid and long term care.

For more than a decade, Congress has encouraged prepaid, integrated systems of primary, acute and long term care—through the Social Health Maintenance Organization (SHMO) and the Program for All-Inclusive Care for the Elderly (PACE) demonstrations. All of the evidence is not in, but experience to date suggests that these are mechanisms for achieving real cost savings while maintaining very frail people in the community and providing high quality care. The initial PACE projects have shown savings to Medicare of 9% to 34%, beyond the 5% reduction already built into the PACE rate-setting method. This is in spite of the fact that a significant amount of the Medicare capitated rate (up to 50% in some sites) is being used for services generally considered to be "custodial" long term care.

The promise of these projects has led the Senate Majority Leader and others to introduce legislation, the PACE Provider Act of 1995, to encourage expansion of these programs and establish a provider category for reimbursement under Title XVIII and Title XIX of the Social Security Act as well as provider pay.

Other members of Congress are considering legislation that would encourage the development of even broader networks for chronic care, pointing to innovators like the Henry Ford Health Care System in Michigan, the Benjamin Rose Institute in Cleveland, and the Albert Einstein Institute Healthcare Network in Philadelphia, that are breaking down the distinctions between acute and long term care and addressing the needs of the whole person. We agree that this is a direction we need to explore fully. But by block granting Medicaid and removing federal responsibility for long term care, we would be moving in exactly the opposite direction.

Managed care presents unique concerns for the elderly because of their complex health needs. But if we have any hope of making it work, especially for the frail elderly and people with chronic illness and disability, we need to find ways to put providers at risk for all of the care an individual needs instead of increasing incentives to shift the responsibility elsewhere. Until we do, we will encourage fragmented services, inefficiency, and waste. And we leave open the potential for fraud and abuse as vulnerable seniors are shunted back and forth between payers and providers, with no one assuming full responsibility. We still have a lot to learn about how to do this right, but it is a real opportunity that we cannot afford to abandon if we want to achieve real cost savings in health care for the elderly and the chronically ill.

Summary and Conclusion

The Alzheimer's Association is prepared to work with you to try to improve Medicaid and reduce costs. Reductions of the magnitude proposed, however, will have a significant impact on coverage for millions of older Americans. We must be realistic about savings that can be achieved while protecting the vulnerable elderly who now have no other recourse than Medicaid to meet their basic health care needs, including long term care.

To summarize our recommendations, the Alzheimer's Association urges Congress to:

- Maintain the entitlement status of individuals under the Medicaid program.
- Allow growth in the program sufficient to meet the growth of the population eligible for assistance, and inflation in the costs of the services they need.
- Maintain a federal role in the Medicaid program.
- Require that state match federal funds they receive for Medicaid purposes.
- Require that states continue to provide long term care that includes home and community care as well as institutional care.
- Retain spousal impoverishment protections in the long term care program.
- Maintain federal nursing home quality standards and effective enforcement of those standards. Key principles—individualized care, personal autonomy and dignity, quality of life, and maximum function—should form the basis of quality assurance in all long term care settings.
- And finally, encourage coordination and integration of primary, acute and long term care. (This is as important to the future of Medicare as it is to Medicaid.)

In closing, Mr. Chairman, I cannot help but express the frustration I am sure we all share over the focus of today's hearing. We understand that the budget resolution forces you to operate under these constraints. Unfortunately, some of what Con-

gress may do to restrain the growth of Medicare and Medicaid is likely to exacerbate problems in the health care system as a whole—increasing the numbers of uninsured, shifting costs to the privately insured, and adding new burdens to state and local taxpayers. Real health care cost containment has to come through reform of the entire system. We look forward to the day when we can get back to that larger debate.

Mr. BILIRAKIS. Thank you very much, sir.

Ms. Waxman.

STATEMENT OF JUDY WAXMAN

Ms. WAXMAN. Thank you very much, Mr. Chairman, for allowing me to testify here this morning on this important subject which is Medicaid.

Families USA speaks for the consumer in the health care system. We understand that in the interest of deficit reduction, some savings must be achieved in the Medicaid program. But we are afraid that the level and the structure of the cuts that are proposed here will create millions of more uninsured Americans and hinder access to essential health care.

We do not believe that transforming an entitlement to individuals into a block grant for States will achieve the objective of achieving reasonable savings and we stand ready to work with you to find ways to do so but what we have heard proposed so far we think is not the answer.

We have recently issued a report which I have here, entitled "Hurting Real People, the Human Impact of Medicaid Cuts", and I have actually appended a copy of it to my testimony so I assume it will be part of the record.

The reason we did that is we wanted to show what funding that is very deep and the repeal of an entitlement might do to some real types of people and we have 10 stories here, long-term care stories, low-income children, people with disabilities, people who lose jobs through changes in the economy, people who are trying to get off welfare and other protections and I recommend it highly as reading for the members of the committee.

But there is one type of person that I would like to highlight today and that is the low-income senior that has benefited from Medicaid.

Let me give you a little background on the qualified Medicare beneficiary program in case others here in the room don't really know of it. Under current law, low-income Medicare beneficiaries are entitled to some assistance with their Medicaid cost sharing. If your income is under 100 percent of poverty, and that is about $7,500 for an individual and $10,000 a year for a couple, then Medicaid will pay for your Medicare premiums, copayments and deductibles. If your income is between 100 and 120 percent of poverty, then Medicaid will pay for your Medicare premiums.

Let me talk about Doris Brisson as an example of millions of low-income seniors who would be hurt by a block grant that would very likely eliminate this kind of protection that she gets from significant costs. Ms. Brisson is an almost 66-year-old woman who lives near Dallas in Mesquite, Texas. If not for the QMB program, she would have to choose between eating and seeing a doctor, despite the fact that she is actually eligible for Medicare. Her entire income is about $512 a month, which is about 80 percent of the pov-

erty level and yet it is the QMB program that allows her to use Medicare so she can actually participate in Part B and have her cost sharing paid so she can go to see the doctor.

She was widowed almost 30 years ago and left to raise eight children by herself. For many years, she worked on an assembly line at Texas Instruments and as a cook in a child care center and what happened in 1981 was that she became disabled herself. So for many years, she was actually eligible for Medicaid as a disabled person. And then when she turned 65 she was really in for a surprise because then she became eligible for Medicare. Well, she was very frightened because she learned that, one, Medicare doesn't pay for her prescription drugs, of which she needs many unfortunately, and also she was afraid she would not be able to pay for her Part B premiums or other cost sharing.

She was living in Colorado at the time and what she found out was that her income was actually low enough to have her qualify also for Medicaid in that State at that time so, indeed, her cost sharing and drugs were paid by the program.

Then she moved back to her home State of Texas a few months after her birthday and she was shocked to learn that that low income level did not qualify her for Medicaid in the State of Texas. But she did learn, happily, that at least the Federal law required that everybody whose income was under poverty would get the QMB protection for Medicare cost sharing, so at least those expenses would be paid.

Now, she does struggle to pay for her prescriptions. In fact, she goes without a lot of them. She has very little money. Just last week, I had a conversation with her on the phone and she said that she really was worried that if the Federal law changed and there was a block grant and her QMB assistance disappeared, she was not sure she could survive. She is not sure she can pay her Part B premiums or ever go to the doctor, even though she is eligible for Medicare.

And Ms. Brisson unfortunately is not alone. About 6 million low-income seniors can get protection under Medicaid for this Medicare cost sharing.

Mr. BILIRAKIS. Please summarize, if you will, Ms. Waxman.

Ms. WAXMAN. Okay. Let me just say we all know Medicare out-of-pocket costs are rising already, we know that they are very likely to go up even more under the rules of the budget resolution and what changes will come to Medicare and we heard Ms. Checkett from APWA this morning talk about how States don't really want to have to pick up those increased cost sharing and Medicaid. So what is going to happen to the individuals like Ms. Brisson and the other millions of people? And what I will say in summary is, it is quite clear to us that States are unlikely to continue the QMB program especially if they are given all this extra flexibility and drastically less money. It is Americans like Doris Brisson who will pay the price for block grants and drastic cuts in Medicaid.

Thank you.

[The prepared statement of Judy Waxman follows:]

PREPARED STATEMENT OF JUDY WAXMAN, DIRECTOR OF GOVERNMENT AFFAIRS, FAMILIES USA

Mr. Chairman and Members of the Committee: My name is Judy Waxman. I am the Director of Government Affairs at Families USA. We are a non-profit organization that speaks on behalf of consumers of the health care system. Thank you for inviting me to testify on the Medicaid program.

The Medicaid program provides basic health and long term care services to over 33 million American men, women, and children. Transforming Medicaid into a block grant to the states will jeopardize coverage for these seniors, families, and persons with disabilities at a time when employers are dropping coverage and the number of uninsured persons continues to rise.

We understand that, in the interest of deficit reduction, savings must be achieved in the Medicaid program. However, extreme and disproportionate cuts in the Medicaid program will result in more Americans uninsured and in poor health and disincentives for providers and private payers. We stand ready to work with you on ways to achieve reasonable levels of savings without endangering the access of millions of beneficiaries to essential health care. We do not believe that transforming the entitlement to individuals into a block grant to states would achieve these objectives.

To illustrate the various aspects of the Medicaid program that provides coverage and protections, Families USA issued a report looking at ways the Medicaid program touches the lives of millions of Americans. *Hurting Real People: The Human Impact of Medicaid Cuts* explores ten important aspects of the Medicaid program that may be lost if funding is cut too deeply and/or if the program is repealed and replaced with a "block grant" to states.

Long Term Care: Too few Americans realize that Medicaid is the primary public program providing long term care and that more than one-third (35 percent) of the total Medicaid budget is spent on long term care. Medicaid paid $69.6 billion for nursing home care for those who could not afford to pay for their care in 1994; this is more than half the total national bill for nursing home care. Medicaid also paid around $6.7 billion for long term care in the home or the community in 1993.

Low-Income Children: Beginning in 1984, Congress has taken steps to increase the number of low income children who have access to medical care. As a result, all children up to age six and pregnant women can be covered by Medicaid if their family income is below 133 percent of the federal poverty standard. Coverage for older children, with incomes up to the poverty line, is being phased in over 12 years. And the federal government now picks up part of the tab if states wanted to expand coverage to pregnant women and infants in families with incomes up to 185 percent of poverty.

Nursing Home Quality Standards: In 1987, in the wake of several nursing home scandals, Congress enacted Medicaid Nursing Home Reforms. These standards established requirements for staffing and staff training; provided for a comprehensive assessment of each patient as the basis for developing a plan of care; created a "Bill of Rights" for nursing home residents that included the right to refuse treatment, to choose activities, and to be free from unnecessary physical or chemical restraints; and required states to develop a coordinated enforcement plan.

Managed Care Consumer Protections: As with nursing homes, a series of abuses by managed care plans serving Medicaid beneficiaries led to federal regulation. Medical audits, evaluations of the quality of plans, federal review of state plans for Medicaid managed care, and the right of beneficiaries to hearings and appeals have been spelled out in a series of federal laws and regulations. There is a danger that states, under pressure to cut Medicaid costs and impatient to do so by increasing reliance on managed care, may jettison these necessary consumer protections.

Protection Against Spousal Impoverishment: Until 1989, a woman whose husband went into a nursing home was in danger of being left destitute, with virtually all her income and resources required to pay for her husband's care. Congress enacted a law protecting the spouses of nursing home residents. The "spousal impoverishment" provision increased both the monthly income and overall assets the spouse remaining in the community could retain.

People Who Lose Jobs Due to the Economy: Medicaid has a doubly beneficial role during economic hard times; it helps families when a breadwinner loses a job in a recession by giving them some protection against medical catastrophe. And it is "counter-cyclical"; it helps the local economy by pumping additional funds into it and preventing a deepening of the recession.

Persons With Disabilities and Special Needs: Current Medicaid law protects the nearly 5.5 million persons with disabilities who are served by the program, guaranteeing them certain basic services that are medically necessary. Because of their

special needs, most states so far have exempted persons with disabilities when requiring Medicaid beneficiaries to enroll in managed care. As funding and regulatory control decrease, states will be under pressure to dump persons with disabilities into managed care without regard to the adequacy of the programs and their ability to meet special needs.

Affordable Health Care: Medicaid requires states to provide beneficiaries with a minimum package of necessary services and prohibits charging beneficiaries more than nominal premiums, copayments or deductibles. States are already beginning to curb benefits and increase cost-sharing requirements. As Medicaid funding is cut, this trend can only accelerate, leaving beneficiaries no choice but to forego needed care.

Low-Income Seniors: Millions of elderly persons are unable to qualify for Medicaid despite having incomes below the poverty level. Poor seniors spend, on average, one-third of their income paying their Medicare premiums, deductibles, copayments and other health costs not covered by Medicare. The Qualified Medicare Beneficiary (QMB) and Specified Low Income Medicare Beneficiary (SLMB) programs help poor seniors and near-poor seniors pay Medicare cost-sharing.

Welfare-to-Work Incentives: As Congress moves to encourage—or force—welfare recipients to get jobs, transitional Medicaid will be an essential element of a successful welfare-to-work program. The low-wage jobs available to most welfare recipients typically do not provide employer-paid health insurance. Transitional Medicaid benefits now allow beneficiaries to continue receiving Medicaid for a period of time while they are working, giving them a chance to get on their feet.

Our entire report is appended to this testimony so that you can read the stories of the "real people" who would be affected by changes in Medicaid.

There is one aspect of Medicaid I would like to highlight in my testimony today: **Protection for Qualified Medicare Beneficiaries (QMBs).**

Background on QMB program

Current law protects low-income Medicare beneficiaries from Medicare-related out of pocket costs. The QMB benefit pays Medicare premiums, deductibles and copayments for Medicare beneficiaries who have income below the federal poverty guideline. The Specified Low Income Medicare Beneficiary (SLMB) benefit pays Medicare Part B premiums for Medicare beneficiaries with incomes between 100 and 120 percent of the federal poverty guideline. Currently, states administer these benefits as part of the Medicaid program and states pay a share of the cost. States have consistently sought to be relieved of the responsibility.

Doris Brisson

Doris Brisson is an example of the millions of low income seniors who would be hurt by a block grant that would very likely eliminate her protection from significant costs.

Ms. Brisson is an almost 66 year old woman who lives near Dallas, in Mesquite, Texas. If not for the QMB, or Qualified Medicare Beneficiary program, Ms. Brisson would have to choose between eating and seeing a doctor despite her eligibility for Medicare. Ms. Brisson's entire income is now $512 a month from Social Security which is about 80% of the federal poverty line for a single person. Even though her premiums are paid by the program she could not see a doctor if not for the fact that her deductible and coinsurance are also paid. The QMB program allows her to use Medicare when she might not have the necessary cash to do so.

She was widowed almost 30 years ago and left to raise eight children alone. She worked on the assembly line at Texas Instruments and as a cook in a child care center to supplement her husband's survivor benefits. In 1981, she became disabled. For many years she qualified for Medicaid as a person with disabilities.

When she turned 65 an interesting thing happened: she became eligible for Medicare. She was concerned that Medicare alone would not be sufficient for her since she could not afford the Medicare cost sharing and Medicare would not pay for the many prescriptions she needs. She learned, however, that in Colorado where she was living at the time, her income was still low enough so that she remained eligible for Medicaid. Medicaid paid for both her Medicare cost sharing and for her drugs.

A few months past her 65th birthday, she decided to move back to her home state of Texas. She was shocked to discover that her income was too high to qualify for Medicaid under Texas law. She was concerned that even Medicare would be out of her financial reach. She was advised that she did qualify for the QMB program because federal law requires that everyone whose income is under the poverty level is eligible. She was relived that at least her Medicare cost sharing would be paid.

She still has great difficulty paying for her prescription drugs. She needs drugs for arthritis, high blood pressure, depression, and ulcers. Right now she can only afford to pay for her high blood pressure medication which is $60 a month. She goes without prescribed medications in order to pay her rent, electricity, phone, and food. Just last week we had a conversation in which she told me that she was afraid that without the QMB assistance she would not be able to go to the doctor even though she has Medicare. She is afraid that she will not survive. If Medicaid becomes a block grant it is very likely that Medicaid will no longer pay her Medicare cost sharing. She and millions of seniors like her are panicked about what their lives will be like.

Ms. Brisson's story also illustrates that states already enjoy significant flexibility in the Medicaid program, and that state flexibility is not almays in the best interest of the beneficiary. Imagine her shock when she learned that returning to her home state meant she would lose a significant part of her health care coverage. No wonder she's worried that a Medicaid block grant would mean that she will also lose her QMB protection.

Ms. Brisson is not alone: Six Million Low-Income Senior Citizens Can Get Protection Under Current Medicaid Law

The federal poverty guideline is $7,470 for one person and $10,030 for a couple in 1995. Almost five (4.7) million Medicare beneficiaries have incomes below the poverty line and are eligible for QMB benefits.[1] An additional one million persons age 65 and over have income between 100 and 120 percent of poverty and are eligible for SLMB benefits.[2] (See Figure #1)

These low-income senior citizens and other modest income seniors cannot afford higher out-of-pocket health costs. As of 1994, poor elderly persons spent about one-third of their incomes (34%), on average, on out-of-pocket health costs, excluding any nursing home costs (See Figure #2). These out-of-pocket costs include items not covered by Medicare, such as long term home care, prescription drugs, dental care and Medigap premiums; and Medicare-related out-of-pocket costs for deductibles, premiums and copayments.[3]

Medicare Out-of-Pocket Costs Are Rising

Premiums, copayments and deductibles under Medicare have escalated rapidly over the last fifteen years. In 1980, a Medicare beneficiary with one hospitalization and average Part B copayments paid out-of-pocket costs of $492 per year. By 1995, the costs of Medicare premiums, deductibles and copayments for a beneficiary with one hospitalization had increased 273 percent, totaling $1,836 per year. This is one-fourth of a poverty-level income.

Medicare-related Out-of-Pocket Costs

	1980	1995	Percent Increase
Part A Deductible	$180	$716	+298
Part B Premium	104	553	+431
Part B Deductible	60	100	+66
Part B Copayments*	148	**467	+215
Total	$492	$1836	+273

*Average per beneficiary
**Estimate based on average 1992 amount adjusted for the increase in Medicare expenditures per enrollee.

Out-of-Pocket Costs Are Likely to Increase Even Further Under Proposed Budget

Medicare-related out-of-pocket costs will undoubtedly increase in the coming years. The Department of Health and Human Services has estimated the likely impact on beneficiaries of the Congressionally-adopted Budget Resolution. Assuming that half of the Medicare reductions affect beneficiaries, Medicare-related out-of-pocket costs will be $625 more in the year 2002 than current projections. By 2002, Medicare beneficiaries will pay $2,675, on average, for premiums, deductibles and copayments alone.[4] On top of these expenses, Medicare beneficiaries continue to have increasing out-of-pocket expenses for prescription drugs and other services not covered by Medicare.

States Do Not Want the Responsibility of Protecting Medicare Beneficiaries from Out-of- Pocket Costs

Since the proposed budget will likely increase Medicare copayments, deductibles and premiums, the proposed budget will increase the cost of the QMB and SLMB benefits at the same time that Medicaid funding is being dramatically reduced. The

National Governors' Association has taken the position that "the Medicare program is a federal program and the federal government should bear all of its costs."[5] Governors object to state responsibility for Medicare-related costs.

Conclusion

If not required, states are unlikely to continue the QMB and SLMB program, especially if they are given significantly more flexibility and their funding is severely reduced. Millions of Americans, like Doris Brisson, will pay the price for block grants and drastic cuts in Medicaid funding.

ENDNOTES

[1] Peter J. Neumann, Mimi D. Bernardin, Ellen J. Bayer and William N. Evans, *Identifying Barriers to Elderly Participation in the Qualified Medicare Beneficiary Program* (Washington, DC: Project HOPE Center for Health Affairs, August 23, 1994).

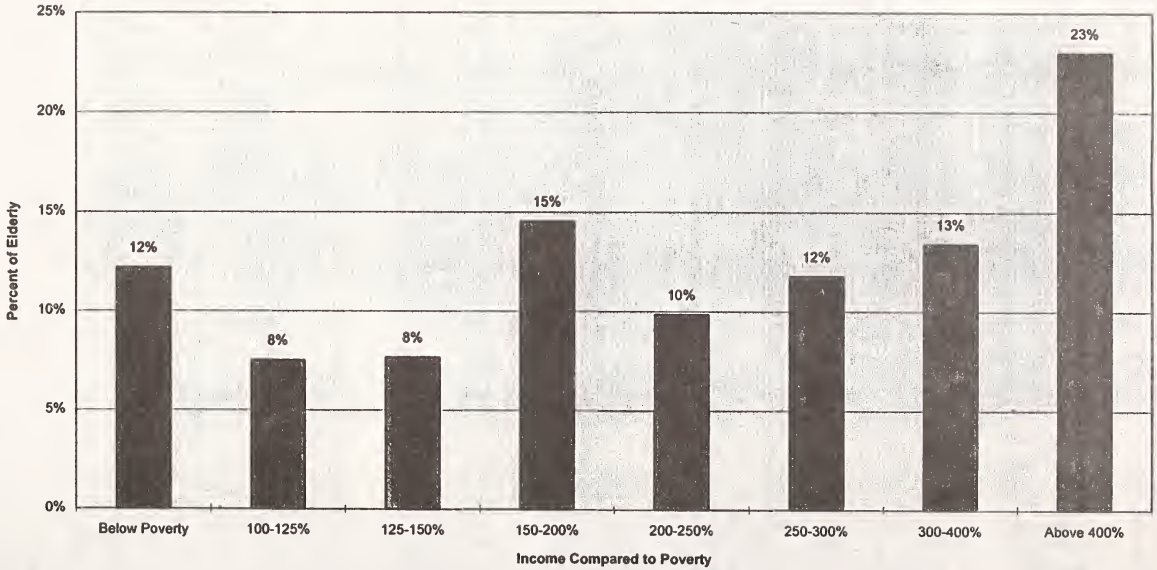
[2] U.S. Bureau of the Census, *Income, Poverty and Valuation of Noncash Benefits, 1993* (Washington, DC: US Department of Commerce, Bureau of the Census, P-60, Number 188). Figures exclude senior citizens living in nursing homes or other institutions; Families USA, *The Medicare Buy-In: A Promise Unfulfilled* (Washington, DC: Families USA Foundation, March 1993).

[3] AARP Public Policy Institute and The Urban Institute, *Coming Up Short: Increasing Out-of-Pocket Health Spending by Older Americans* (Washington, DC: American Association of Retired Persons, 1995 update). Medicare deductibles, premiums and copayments were paid by persons not receiving QMB benefits.

[4] U.S. Department of Health and Human Services estimates, assuming that beneficiaries are liable for 50 percent of Congressionally proposed Medicare cuts.

[5] National Governors' Association, *Policy Positions* (Washington, DC: National Governors' Association, January 1995.

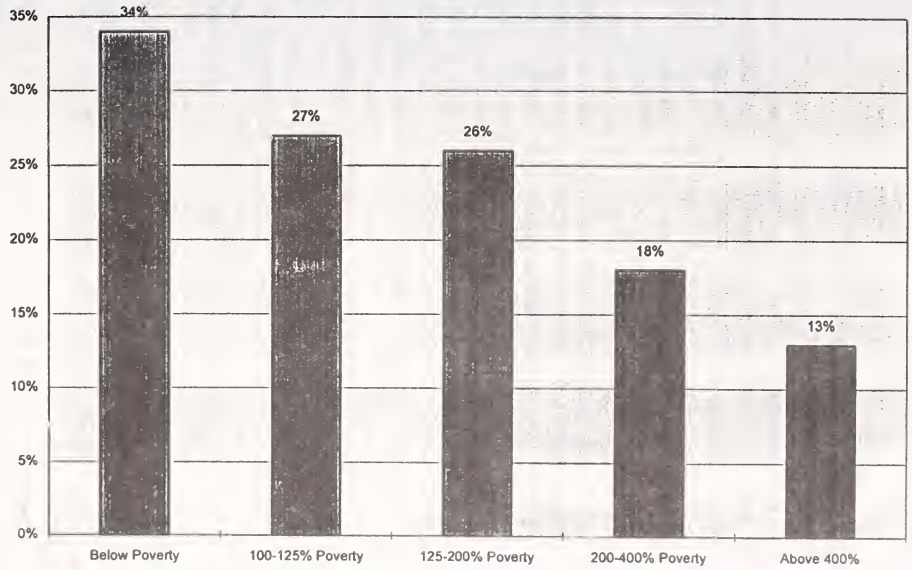
Distribution of Elderly By Income As a Percent of Poverty, 1993



Source: U.S. Bureau of the Census, *Income, Poverty and Valuation of Noncash Benefits, 1993.*

Figure 1

Elderly Out of Pocket Health Costs As A Percent of Income, 1994



Source: "Coming Up Short: Increasing Out-of-Pocket Health Spending by Older Americans," prepared by AARP Public Policy Institute and the Urban Institute, updated February 1995. Excludes long-term nursing home care.

Figure 2

Mr. BILIRAKIS. Thank you so much.
Dr. Willging.

STATEMENT OF PAUL WILLGING

Mr. WILLGING. Mr. Chairman, I appreciate the opportunity to testify before this committee today. The American Health Care Association represents some 11,000 not-for-profit and profitmaking assisted living facilities, some acute units and nursing facilities across the country. You have posed a real challenge for us all, Mr. Chairman, the transformation of the Medicaid program and I think I would like to start by suggesting it does need transformation.

There is no question that this program is leading more and more States to the point of fiscal meltdown. It is a burden in terms of both Federal and State public funding becoming increasingly difficult to bear. This is true for both sides of the Medicaid program and I think we have to bear in mind that Medicaid really has two programs in it. One is the more traditional acute care program for the more traditional welfare population. The other is the long-term care program with a different population, a different set of services and I think we have to talk about those programs separately because they lend themselves to different types of solutions.

Certainly when dealing with long-term care, and I speak to long-term care, my area of expertise, we—that is you and I, do differ in terms of a solution. We are not convinced that the way to transform the Medicaid program is by transferring the program, transferring the problem, if you will, to State governments. We think that transferring the problems is not equivalent to transferring the programs.

For the sake of discussion, I am willing to leave alone the argument that on the acute care side, enhanced flexibility given to the States may indeed provide the kinds of saving that are anticipated in the budget resolution. That clearly, however, is not true with respect to long-term care.

If you take the 37 percent of the Medicaid program that goes into long-term care today, multiply that by the billions anticipated in the budget resolution, we are talking about a total of $67 billion in savings from long-term care alone. Given the history of long-term care in the Medicaid program, those savings can only come from two sources: Dramatically reduced services in terms of population or the actual quality of the service provided or increased taxes by the States. There are no other alternatives.

Now, that may sound simply like a lobbyist talking as a lobbyist must to protect the program that pays his salary but I think to see that that is true, you have to look at the causes for growth on the long-term care side of Medicaid. They have very little to do, quite frankly, with the parameters and the strictures laid on States by the Federal Government in terms of Medicaid. They have to do with demographics, they have to do with acuity of services. No matter how much additional flexibility is provided States in a block grant with respect to long-term care, that flexibility will not help them stem the demographic tide facing this country. That flexibility will not help them change the acuity levels of residents in nursing facilities today. Flexibility can't stop demographics.

Now, one will argue the Boren Amendment, of course, is a matter of State flexibility. Well, quite frankly, I disagree with those who suggest that the Boren Amendment is a problem for the States. The Boren Amendment and its repeal is nothing more than an excuse looked to by the States so as not to pay for the services they buy.

There is already a $13.9 billion subsidy paid by private pay patients in nursing facilities because of a current State unwillingness to pay the cost of the efficient and economically managed facility. So what do we do?

If I agree as I do that Medicaid needs to be transformed, if I agree as I do that we need to find a way to ease pressure on public funding but if I disagree with the transformation being the same as block grants, what is the solution available to us? I think we need to maintain Federal oversight and involvement so as to perform a truly radical transformation of the Medicaid program. I think we have got to stop paying lip service, Mr. Chairman, to the so-called public/private partnership and actually do something about it. I think we've got to change the program so that it is indeed a safety net only for the poor. I think we do that by emphasizing in ways we have not yet followed the concept of asset transfer prohibitions.

This Congress, this committee has passed legislation in the past to work on that problem but up to this point it has been more ignored than implemented by the States. And the Heritage Foundation has suggested there is still $5 billion per year that could be saved by more rigorous approaches to asset transfer.

I think we have finally got to do something at the Federal level in terms of long-term care insurance that will not give you a 1-year, a 5-year or perhaps even a 7-year savings of $67 billion but it will finally orient the program toward a true public/private partnership where Medicaid is preserved and reserved for those who truly need it and not used for those who should be, through long-term care insurance, planning for their own possible need for long-term care services.

Finally, we've got to look at ways where the long-term care side of Medicaid can in fact serve as a safety valve for the acute care side. I was impressed a few months ago when the Governor of California found in his budget the ability to save $200 million per year in California alone by utilizing skilled nursing facilities to do the sub-acute type of service that heretofore has been provided only in hospitals. There are ways of truly transforming this program and I would suggest we work on those, Mr. Chairman, rather than simply transferring the problem to the States.

Thank you very much.

[The prepared statement of Paul Willging follows:]

PREPARED STATEMENT OF PAUL WILLGING, PH.D., EXECUTIVE VICE PRESIDENT, AMERICAN HEALTH CARE ASSOCIATION

Mr. Chairman, members of the committee, my name is Paul Willging, Executive Vice President of the American Health Care Association (AHCA). AHCA is a federation of 51 affiliated associations that represent more than 11,000 non-profit and for-profit assisted living, nursing facility, and subacute care providers nationwide.

I am pleased to have this opportunity to testify before the committee today on the issue of Medicaid reform, especially as it relates to long-term care benefits and services. The Medicaid program is a jointly financed, federal-state partnership. Enacted

in 1965, its goal is to extend a wide range of health care services to low-income Americans. The underlying premise of this program is that states, in order to qualify for federal funding, must adhere to minimum requirements for eligibility and services set by the Federal government. From the outset of my testimony, I want to make it clear that AHCA believes that this fundamental principle of the program—Federal oversight and direction of state implementation of the several Medicaid programs offered by the individual states, should be retained in any structural realignment the Congress may ultimately adopt.

At this point, I would like to comment on the nature of the problems facing the Medicaid program today, and to then address the major reform proposal under consideration by this committee, which is the establishment of a block grant funding mechanism for long-term care services currently provided under the Medicaid program.

Medicaid and Long-Term Care

Data extracted from the Health Care Financing Administration's (HCFA) most recent (1993) Medicaid Statistical Information System show that there were 1,609,718 recipients of Medicaid nursing facility services in 1993, compared to 1,572,946 in 1992. Medicaid utilization as measured by days rose 9 percent between 1992 and 1993. However, the number of recipients accounting for those days rose only 2.3 percent. Thus the length of stay for Medicaid beneficiaries has been increasing.

Nursing facility services comprise the single largest part of the Medicaid program in most states. Even so, data show that nursing facilities' share of total state Medicaid dollars is actually shrinking relative to other Medicaid spending. (Source: HCFA's Office of the Actuary, National Health Expenditures, 12/93) Despite this relative slowdown in expenditures, demographic trends point to increased utilization of institutional long-term care services in the foreseeable future. In fact, the Census Bureau estimates that the elderly population will continue to rise through the beginning of the 21st century, then take a dramatic jump of nearly three-fold between 2020 and 2050 as the "baby boomer" generation enters old age. These factors, compounded with a strong potential for an increased acuity level of future nursing facility residents point to both a greater demand for services and increased need for more skilled personnel and services.

Block Grants

The proposal for transforming the nation's long-term care financing system now receiving the most serious consideration would convert the federal-state Medicaid program into a "block grant" to the states. Because no specific block grant program has been formally proposed, I am unable at this time to address the details of such a plan. However, as commonly discussed, under a Medicaid block grant the federal government would allocate such a predetermined amount of funding for each individual state's Medicaid program while simultaneously reducing the federal administrative and regulatory requirements placed on those programs.

The American Health Care Association is concerned that transforming Medicaid into a block grant is not a viable way to achieve the savings Congress is seeking. While we understand the budget imperative confronting this Congress, we feel that the Medicaid savings called for under the budget resolution for fiscal year 1996, $182 billion over seven years, is simply too much too fast. We fear that block granting the Medicaid program would result in diminished quality of care for the residents of long-term care facilities, reduce access to necessary long-term care, and eliminate the advances the long-term health care delivery system has made in the past several years. Instead of merely block granting the program, AHCA believes that Congress needs to bring about Medicaid savings in a way that preserves the capacity of our long term care system to provide quality care and builds a private/public partnership to relieve the chronic overburdening of public resources.

Earlier this year, AHCA contracted for a impact analysis of the imposition of a block grant funding system for Medicaid long-term care services. Assuming that $182 billion would be cut from the states' Medicaid programs over a seven-year period, the burden of funding the anticipated reduction in anticipated federal funding would be $67.8 billion for long-term care services alone. This study, "Medicaid Block Grants: A Losing Proposal for the States" is attached to my testimony for your consideration. Despite our best efforts, AHCA can not find that amount of "fat" in the long-term care delivery system to achieve this budgetary goal. We have concluded that the objectives of the budget resolution call for too great a reduction in too short a time frame.

From the perspective of long-term care providers, a block grant funding mechanism for the long-term health care delivery system embodies several liabilities. Following is a list highlighting our concerns:

- **Block Grants Ignore the Real Problems Facing Long-Term Care**—The most important problem facing long-term care is finding sufficient financial resources to fund the demand for services. Block grants simply limit the federal funding, but ignore the real solution which is to create an alternative to government funding. That alternative is more personal responsibility for paying for long-term care—through private long-term care insurance.
- **Block Grants are Unfair to Beneficiaries in Some States**—As proposed by the House and Senate Budget Committees, federal payments to states for Medicaid benefits would remain the same as their FY '95 federal, financial participation (FFP), and increase by a various percentage thereafter. However, the current FFP formula does not allocate federal funds to states with the greatest needs. For example, New Hampshire receives $4,115.00 in federal funds annually per Medicaid enrollee and California only gets $1,259.00 per enrollee. Under the Budget Committee plan, these figures would be "locked in" and their inherent inequities perpetuated. In addition, variables in our economy, such as a recession or a period of inflation, could seriously under fund necessary services.
- **Access to Nursing Home Services Denied**—Demand for long-term nursing facility care has grown over 10 percent annually for the past several years, and is expected to increase beyond that when the "baby boomers" start to need nursing facility services. A cap on annual growth simply restricts already insufficient fiscal resources.
- **Quality of Care Jeopardized**—Increased demand in the face of decreased resources means that the current levels of service cannot be sustained. Subsequently, long-term care providers will be expected to care for more people with less money. With nursing facility profit margins at less than 3 percent annually, it will not take long for providers to begin losing money on the Medicaid program. Because approximately 85 percent of all long-term care providers are proprietary, they will not be able to remain program participants.
- **Economic Viability of Provider Community Jeopardized**—As part of all block grant proposals, an underlying element is the repeal of the current Medicaid payment standard, the "Boren Amendment." Without any federal payment standards, states will be free to set Medicaid payment rates—which are already below the costs of care—anywhere they like. When revenues do not equal expenditures, providers must leave the program or simply go out of business.
- **Too Diverse a System**—Providers offering services in multistate regions already have to deal with the grant system in which the states have even more flexibility than they do now—over levels of service, benefits, and even eligibility levels—providers will have even greater effort and expense in administering their enterprises.
- **Block Grants Reduce Accountability**—Under a block grant system, individual states can have more latitude to use federal financial resources as they see fit. With little or no federal direction as to how these resources are allocated, there is a corresponding decrease in the ability of the federal government to account for how their resources are utilized.
- **Block Grants are Budget Policy, Not Health Care Policy**—The Medicaid program is a health care program. Supporters of block grants are ignoring the problems as well as the solutions necessary to meet appropriate levels of service with fiscal responsibility. By ignoring the health care policy aspects of these problems, Congress fails to resolve the problems of this program while creating devastating effects on the frail elderly.

We are also concerned about the many false expectations supporters of a block grant funding system expect to enjoy. Although it is true that a block grant funding system will be able to specify future budgetary expenditures, we are highly skeptical that the resulting shortfall in resources can be offset by increased efficiencies or by creating alternatives to institutionalization. Following are comments that dispel some of these expectations:

- **Few Managed Care Opportunities for Long-Term Care**—Although the enrollment of Medicaid acute care beneficiaries in managed care plans does hold some promise for increased service efficiencies, there is very little opportunity for utilizing managed care plans for the majority of Medicaid nursing facility residents who are chronically ill. In fact, the majority of state Medicaid reimbursement plans utilize either a prospective per them or a case-mix reimbursement system under which their financial liabilities are anticipated well in advance of service delivery. This is the primary reimbursement feature of managed care plans—knowing your costs before you prescribe the service. Therefore, the efficiencies of managed care for the chronic long-term care population have already been achieved.

- **Increased Flexibility Will Bring Increased Efficiencies**—We are truly puzzled over states' claims that the Medicaid program lacks flexibility. Compared to the only other comparable health care program, Medicare, Medicaid has always enjoyed a substantial flexibility in coverage of benefits, eligibility, service delivery, and financing. Beyond the existing program standards, Medicaid allows for the granting of waivers by the Federal government so that states may experiment with innovative ideas for service delivery.
- **Market-based Economies Will Decrease Costs**—Some have contended that Medicaid payment standards for long-term care services have perverted the market place for services by establishing arbitrary prices. To the contrary, an analysis of payments for 1990 Medicaid nursing facility days reveals that Medicaid was the beneficiary of a $13.9 billion subsidy provided by other (mostly private) payers. (Source: Expenditure Data from Health Care Financing Review, Fall 1992 and The Guide to the Nursing Home Industry, Health Care Investment Analysis's, Inc.) Moving to a market-based economy where the Medicaid programs would have to pay market-related costs for services would result in an increase in Medicaid expenditures, not a savings as envisioned.
- **Home- and Community-Based Services Could Replace Nursing Facility Services**—In recent testimony presented to both this, as well as other Congressional committees, supporters of home- and community-based care (HCBC) have implied that these services are a cost-effective substitute for nursing home care. While AHCA supports the development and expansion of HCBC services, I must note that, unfortunately, this is not the case. Several studies have examined the cost-effectiveness of HCBC services which have concluded that while they are a desirable service, they actually increase the overall costs of long-term care services. This is because where they are currently available, HCBC represents an additional benefit, and not a replacement for institutionalization. Nursing facilities and HCBC services serve two different populations with differing sets of needs.
- **Reducing the Profits of Long-Term Care Providers Will Reduce Costs**—Because the majority of the nation's nursing homes are, "for profit," some have proposed reducing Medicaid expenses by cutting—or eliminating—provider profits. In reality, the profit experience of the long-term care provider community is extremely modest relative to other types of health care providers. According to the 1994, "Guide to the Nursing Home Industry" (HCIA and Arthur Andersen & Co.), investor-owned nursing facilities made a 4.15 percent profit margin in 1992. This hardly represents "excessive" profits by any standard.
- **Reducing Regulatory Requirements will Greatly Lower Costs of Services**—A consistent theme of all block grant discussions is the assumption that under such a plan, the reduced funding levels would be, to some extent, offset by a reduction in regulatory requirements. Although it is quite true that the long-term care provider community is subjected to volumes of both federal and state regulations, the majority of them are related to patient care, and are a necessary part of this health care delivery system. Like virtually all trade associations, AHCA has proposed several regulatory issues for review as part of the current regulatory reform efforts. However, with the magnitude of budget reductions contemplated for the Medicaid program, the elimination of our list of regulations will not make a serious contribution to the ultimate goal of the budget resolution's proposals for Medicaid cuts.
- **Repealing the "Boren Amendment" Will Reduce Costs**—No discussion of long-term care restructuring would be complete without addressing the Boren Amendment. The Boren Amendment, which sets the Medicaid payment standard for nursing homes and hospitals simply states that, "economically and efficiently" operated providers must receive "reasonable and adequate" reimbursements for their services in order to meet state and federal standards for care and service. Prior to the Boren Amendment, Medicaid reimbursements were based upon the existing Medicare, "cost-based" formulas. As my earlier testimony pointed out, Medicaid is greatly underfunding services—*with* the Boren Amendment as a standard. Without preserving the ability to meet a specified level of service, providers are sure to enter into an economic downward spiral that reduces providers' ability to provide quality services and to remain economically viable. I cannot urge this committee strongly enough to preserve the financial integrity of the nation's long-term care delivery system by preserving this payment standard.

Alternative Approaches and Options

As I stated earlier, none of us here can ignore the budget imperative facing our nation. AHCA remains committed to working to implement a sound financing struc-

ture for long-term care services. However, we cannot support simply making predetermined cuts in budgets without first giving thought as to how these cuts will be absorbed within the delivery system.

Simply stated, the financing predicament facing us relative to providing long-term care services is that demand far outpaces financial resources. Given the current budget situation, we recognize that increasing public sector spending is not a tenable proposition. Therefore, we have worked to craft a set of proposals that will shift, to a great extent, the financing for long-term care services from the public, to the private sector. As we address this problem, we have examined all aspects of long-term care service delivery as potential contributors to cost reductions. One of the first areas identified for potential savings already exists; namely, estate recoveries. As part of OBRA '93, this committee proposed, and Congress ultimately adopted, requirements for states to develop a regulatory infrastructure for recapturing Medicaid expenditures through the establishment of an estate recovery process whereby liens would be placed on the homes of deceased Medicaid beneficiaries (only after the demise of a community-based spouse). We are discouraged that the states have demonstrated little interest in utilizing this potential for generating significant sums of money for their Medicaid programs.

Similarly, the artificial qualification for the Medicaid nursing facility benefit through the use of asset transfers continues to plague the system. The growing cottage industry of "elder law attorneys" whose practices show individuals how to shelter income, property, and resources from countable assets for Medicaid qualification deprives this program of resources that instead would be used for the truly needy. One estimate from the Heritage Foundation shows that $5 billion per year for could be saved if states aggressively pursued closing this loophole.

Another area of potential savings that remains untapped lies in achieving additional savings through the expansion of the long-term health care delivery system by further developing a subacute care level of service for Medicaid beneficiaries. Today, individuals in this health care continuum are placed either in acute care facilities, skilled nursing facilities, or nursing facilities. There is a distinct population of individuals whose health care needs which are currently being served in acute care facilities could be appropriately addressed in subacute care units which have gained marked popularity with private insurers and that HCFA is currently looking at as a potential service area for Medicare. One study by Abt and Associates has shown that subacute care has the potential for saving Medicare up to $8.9 billion per year. We would suggest that there is real potential for comparable Medicaid savings.

However, regardless of the potential savings available through paring back existing benefits and services, we urge you to consider making a major shift in the long-term health care system by moving from a public, to a privately financed system.

Shifting from Public to Private Payment for Long-Term Care

AHCA has long supported private long-term care insurance as a means to increase the proportion of nursing facility residents not dependent on Medicaid. For the past several years, AHCA has worked as part of a coalition of long-term care insurers and providers, the Coalition for Long-Term Care Financing, to promote appropriate federal standards for long term care insurance; for legislation that would clarify the federal tax status of private long term care insurance; and for other steps to begin to shift the long-term care cost burden from Medicaid to private insurance.

Our society has not made adequate provision for financing the costs of long-term care. Individuals and families are not saving for, or insuring themselves against, the costs of long term-care. The federal/state Medicaid program is stretched to the breaking point. Families and governments are going broke.

We believe that long-term care financing legislation should have the following goals: providing appropriate access to the full continuum of long term care services; ensuring that all Americans have the means to meet the cost of long term care; moving individuals and families away from dependence on government welfare programs for long term care financing; and addressing the nation's long term care needs in a fiscally responsible way.

Fostering a robust long-term care insurance market is key to meeting these long term care reform goals.

Federal Tax Treatment of Long-Term Care Insurance

AHCA's members feel strongly that, with the right federal policies, private long term-care insurance can become the centerpiece of a private/public long term care partnership that would help families, states, and the federal government meet the costs of long term care. Therefore, we strongly support the provisions of the House-passed Senior Citizens Equity Act that would confer on private long term care in-

surance the same tax advantages already enjoyed by health insurance. Specifically, we support the tax clarification provisions of the legislation that would: clarify that qualified long-term care services are treated as medical expenses; allow long-term care insurance premiums to be deducted as medical insurance subject to the 7.5 percent of adjusted gross income floor; clarify that employer-provided long-term care coverage is deductible as a business expense and excluded from employee income; exclude long-term care insurance benefit payments from income; clarify that an accelerated death benefit received by a terminally ill person is excluded from taxable income; and permit tax-free early withdrawals from Individual Retirement Accounts (IRA) for the purchase of a long term care insurance policy.

Federal Standards and Consumer Protections

Appropriate federal standards and consumer protections for long-term care insurance would inspire consumer confidence; foster the growth of the private long-term care insurance market; and ensure that elderly consumers are spared the problems that once plagued the "Medigap" insurance business. As long-term care providers, we do not benefit from private insurance policies that provide inadequate coverage. Nor do providers benefit from sales practices that lead individuals to purchase inappropriate policies or policies that they cannot afford to pay for. Accordingly, AHCA supports federal standards to ensure appropriate policy design and sales practices.

At the same time, providers and the elderly cannot benefit from private insurance policies priced out of the reach of consumers by federal regulation that is too heavy-handed. Therefore, we recommend that proposed federal standards be balanced by considerations of affordability. Congress needs to consider carefully the trade-off between the value of a policy feature and the cost to consumers of mandating that feature. Balanced and thorough federal consumer protections would help ensure that long term care policies offer value to consumers and that policies pay appropriately and adequately for quality long term care when needed.

Private/Public Partnerships for Long-Term Care

Working with the Robert Wood Johnson Foundation, Connecticut, New York, Indiana, and California have established private/public long-term care partnerships that encourage the purchase of approved long-term care insurance policies by offering purchasers enhanced asset protection under the Medicaid program. Generally, under such a partnership program, if a long-term care insurance purchaser requires long-term care and eventually exhausts his or her insurance benefits, the state will raise the Medicaid asset eligibility threshold by the amount of the long term care coverage purchased.

In a number of states, there is considerable interest in establishing private/public partnerships along the lines of those already underway in Connecticut, New York, Indiana, and California. However, the Omnibus Budget Reconciliation Act of 1993 (OBRA '93) included provisions [Section 13612(a)(C)] that discourage states from implementing such partnerships. Specifically, these provisions require states to make recovery from the estates of those who had enjoyed enhanced Medicaid asset protection. That is, these provisions make a partnership's asset protection only temporary. AHCA supports the repeal of these provisions. States should be permitted to establish "asset protection" programs for individuals who purchase qualified long term care insurance policies, without requiring states to recover such assets upon a beneficiary's death.

Long-Term Care Consumer Education

A public opinion survey conducted for the Employee Benefit Research Institute in the summer of 1994 found that 45 percent of respondents believe that Medicare pays for long term care. This means that even after 30 years of Medicare, the public has not yet been educated about what Medicare is and what it is not. Many beneficiaries are in for a rude awakening should they need long term care coverage.

AHCA supports legislation that would promote awareness on the part of senior citizens and their families of the potential costs of long-term care, the limits of current public long term care assistance, long-term care insurance options, and of information necessary to be a smart long-term care insurance consumer. In addition, AHCA suggests that the federal government's Medicare and Social Security beneficiary information mailings could include long term care insurance consumer information. At the least, the use of Social Security and Medicare beneficiary information could provide the public service of correcting the widespread belief that Medicare covers long-term care.

There is a Better Idea

Congress can provide elderly Americans with long-term care coverage without making them poor—and without pushing responsibility for long-term care onto the

states under an arbitrary growth limit. Instead, Congress can meet the crucial needs of the elderly through an enhanced private public partnership based on private long-term care insurance.

The nation created **Medicare** because Americans did not think it was right to let the costs of care for sickness or injury bankrupt senior citizens after a lifetime of work, taxpaying, and self-sufficiency. Yet **Medicaid** *requires* that those who have worked and paid their own way for a lifetime must lose everything before they can get help with long term care. It is a welfare program. It is time to change this—*to move long term care from welfare to health care.* By relying on private long term care insurance, Congress can transform Medicaid long term care without increasing federal budget deficits.

Instead of block-granting Medicaid long-term care to the states, Congress should: maintain a strong federal role in long-term care; integrate long-term care and Medicare's acute care coverage; establish the strongest possible incentives to get Americans to plan for, save for, and insure against long-term care costs; set income-related cost sharing that would target government assistance to those most in need *AND* prompt those who can afford it to insure against long-term care costs; and give the Secretary of Health and Human Services the authority to phase in new coverage only as means are found to offset their costs with budget savings or revenues.

Moving long term care from a "welfare entitlement" to a federal "health insurance" benefit would: end the requirement that the elderly impoverish themselves to get long-term care help; remove the stigma attached to long-term care recipients; facilitate the creation of a "seamless" web of care for the elderly; make things easier for beneficiaries to understand; simplify administration and eliminate multiple layers of government; facilitate coordinating private long-term care coverage with government coverage; and reduce dependency on government funding.

Conclusions

Fiscal necessity and pragmatism clearly show that government cannot continue to bear an increasing financial burden of long-term care. Private sector ways and means must be harnessed in partnership with public programs and resources. We urge the committee to resolve these problems with a policy that is more thoughtful and comprehensive than the imposition of a block grant system by examining all of those factors that make up such an important part of our nation's health care delivery system. We are committed to working with you to create an economically sound, quality-oriented, long-term health care system for our nation.

AHCA is pleased that this Committee is considering important questions bearing on the future of long-term care financing. Thank you for including us in your deliberations.

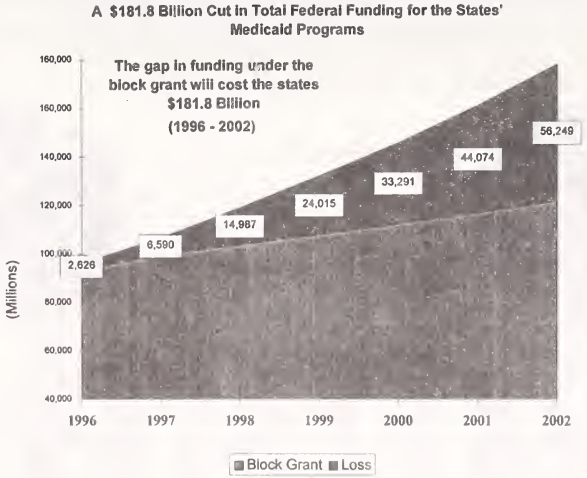
Medicaid Block Grants: A Losing Proposal for the States

An analysis of the impact of the implementation of a Medicaid block grant program, as specified by the Congressional Budget Resolution

Concurrent Resolution on the Budget for Fiscal Year 1996 (adopted June 26, 1995)
H.Con.Res.67 House Report 104-159

States Lose $182 Billion in Seven Years Under the Medicaid Block Grant Proposal

Congress has agreed on a Medicaid block grant proposal that would reduce growth in federal funding by $182 billion from 1996 to 2002[1].



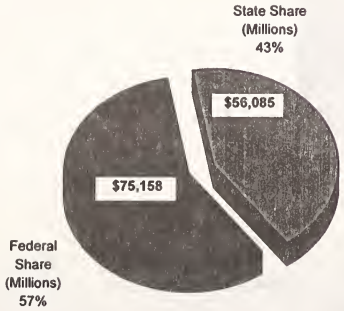
The above chart shows the growing losses in federal Medicaid dollars that the states face under the block grant proposal. States will lose a total of $182 billion during the seven year period from 1996 to 2002.

[1] American Health Care Association modeling based on projections from Holahan, John & Liska, David "The Impact of a Five Percent Medicaid Expenditure Growth Cap: A State Level Analysis," (Washington, DC: The Kaiser Commission on the Future of Medicaid, Policy Brief, March 1995).

Block Grants Would Shift the Burden of Medicaid to the States

Medicaid funds in 1993 consisted of $56 billion from the states and $75 billion from the federal government. The federal government currently pays 57% of the states' Medicaid bills. The net effect of the block grant proposal is that the federal government's share of Medicaid funding decreases from 57% to 42% - or $121 billion - by 2002.

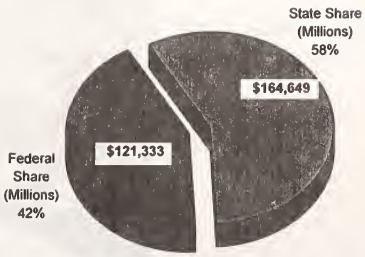
Burden of Medicaid Payments 1993



In 1993, the states paid 43%, or $56 billion, of the total Medicaid budget.

Burden of Medicaid Payments 2002

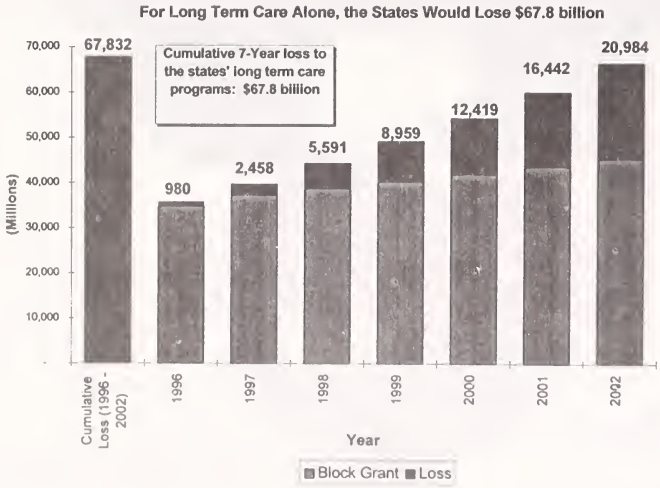
Under the block grant proposal



Under block grant proposal, the states' share of the Medicaid budget jumps to 58%, or $165 billion, in 2002.

Block Grants Jeopardize Long Term Care in the States

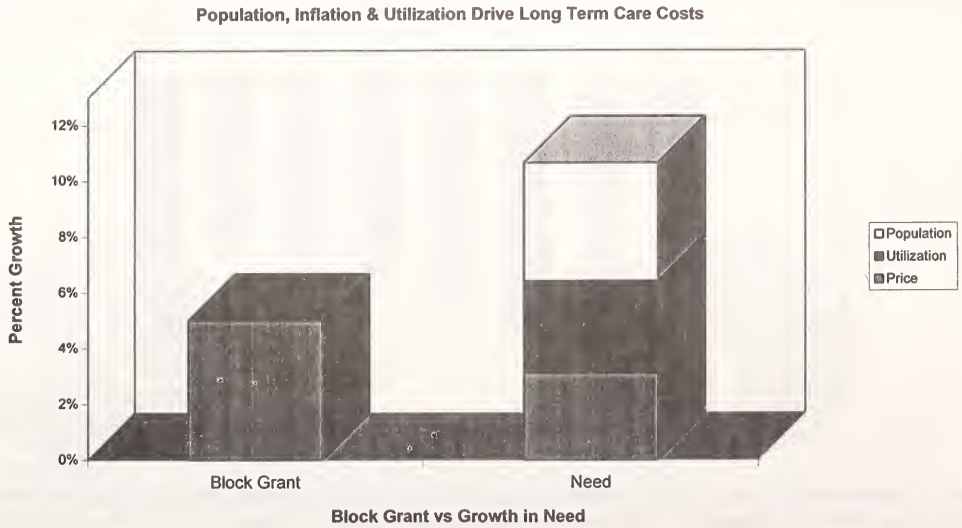
Medicaid does not simply provide health care to the poor. The program also meets the long term care needs of the frail elderly. In fact, 69% of the 1,513,886 nursing home residents - 1,042,218 residents - currently rely on the Medicaid program to pay for their long term care. If long term care continues to constitute 37% of the total Medicaid program, block grants will cut federal funding for nursing home residents by nearly $68 billion between 1996 and 2002.



Between 1996 and 2002, states will lose $68 billion in federal Medicaid payments for long term care alone.

Block Grants Won't Keep Pace With the Need for Long Term Care Funding

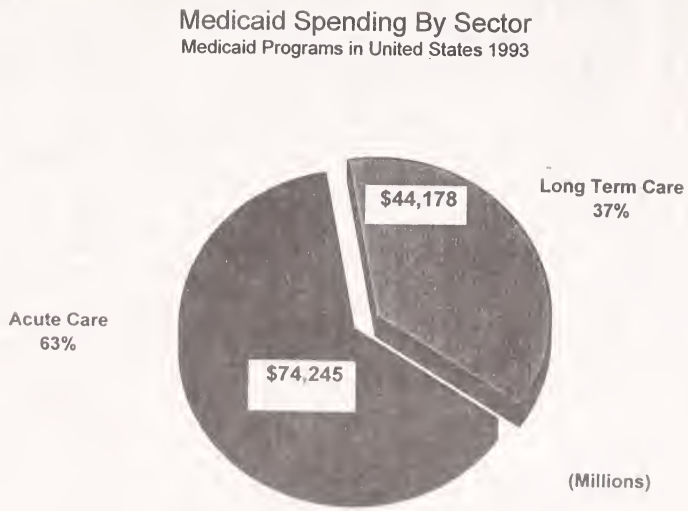
On top of price inflation, population increases coupled with increased use of more medically intensive services will far outstrip the federal government's declining growth rate for Medicaid block grants to the states.



The block grant proposal limits annual Medicaid growth to a declining percentage between 7.2% and 4% per year. Between 1993 and 1994, growth in Medicaid expenditures was about 10%. The states' long term care growth rate is driven by increases in population, the need for more intensive services, and general price inflation.

Medicaid Long Term Care Expenditures

States spend 37 cents of every Medicaid dollar on long term care. Cost saving measures like managed care have not been tested in long term care, and current alternative services have not yielded cost savings. With managed care savings proving elusive and a growing elderly population inevitable, cuts in federal funds for long term care mean state lawmakers face tough decisions about how they will care for the disabled and frail elderly.



Long term care accounts for 37% of the Medicaid budget.

Mr. BILIRAKIS. Thank you very much, Dr. Willging. I appreciate very much your logic. I would say that if many of the areas that you mention had been in place up to now, we probably would not have the problem that we have and would not be faced with the tough, tough decision that we now are faced with.

Ms. Braun.

STATEMENT OF BEATRICE BRAUN

Ms. BRAUN. Mr. Chairman and members of the committee, I am Dr. Beatrice Braun from Spring Hill, Florida, your nearby neighbor, Mr. Chairman. I am a member of the Board of Directors of the American Association of Retired Persons.

Thank you for inviting me to testify today on behalf of the almost 5 million older Americans who rely on Medicaid. Thirty years ago, Medicaid was enacted as a partnership between Federal and State governments to serve the country's most vulnerable populations. For low-income older Americans who cannot afford Medicare's premiums and cost sharing, Medicaid fills in the gap. Medicaid also pays for prescription drugs and other benefits that Medicare doesn't cover but low-income seniors can't afford and Medicaid is the only long-term care safety net for frail elderly people who need home care or who have to enter a nursing home.

We know that this committee faces a difficult task in reforming Medicaid and saving $182 billion. These proposed Medicaid reductions are so large that we see little hope that they can be achieved without directly harming Medicaid beneficiaries and significantly increasing the number of uninsured Americans. We also believe that simply boxing up Medicaid's problems and shipping them to the States as a block grant will not work.

I will focus my oral remarks on concerns about the impact of the proposed Medicaid cuts on older Americans. First, how will the Federal Government achieve $182 billion in Medicaid savings without causing significant loss of eligibility. Managed care for elderly and disabled beneficiaries is still largely untested. Innovative approaches to expanding home care as an alternative to nursing home care are desirable but we cannot say that these alternatives would result in large savings.

Second, block grants could permit States to entirely eliminate the QMB that we have heard about. Under the current Federal/State partnership, Medicaid pays the Medicare premiums, deductibles and coinsurance for beneficiaries with incomes below the Federal poverty line. This year, Medicare beneficiaries will spend on average $2,750 in out-of-pocket health care costs to make up for what Medicare does not cover and it seems likely that the $270 billion in Medicare reductions will increase beneficiary out-of-pocket costs substantially.

Eliminating QMB coverage would leave vulnerable low-income seniors unable to afford even the most basic Medicare services. The National Governor's Association has clearly indicated its opposition to the current QMB program with an official statement that the Federal Government should bear all QMB costs. Federalizing the QMB is an option to consider but failing Federalization of QMB, the Governors' statement is indicative of the likely fate of the QMB program if Medicaid is block granted.

Third, the proposed Medicaid-met reductions threaten the long-term care safety net. About 32 percent of Medicaid spending goes for long-term care and Medicaid pays for more than half of the Nation's nursing home costs. Many who need long-term care start off as taxpaying middle class Americans. They worked hard and saved. Then chronic illness strikes, they must spend down their life savings before they can become eligible for the Medicaid long-term safety net. Medicaid is the payer of last resort for persons who have no other way to finance the long-term care they need. The proposed reductions could result in millions of older Americans losing their long-term care safety net.

Fourth, a block grant will allow States to eliminate current nursing home spousal impoverishment protections. Financial protections for spouses of nursing home residents were enacted in 1988 because spouses who remained in the community were often left without income and savings to survive on as their wives or husbands entered a nursing home and the couples spent down to Medicaid eligibility.

Fifth, a block grant could allow States to eliminate successful Federal nursing home quality standards. The Nursing Home Reform Law enacted in 1987 has improved the quality of care in nursing homes by reducing the use of physical restraints and sanctioning nursing homes that continue to allow patient abuse. While States need some additional flexibility, we urge you to preserve the Federal/State Medicaid partnership. Many Federal Medicaid protections were enacted because States were not doing enough voluntarily. Absent Federal requirements there is little reason to be confident that all States will continue to provide them. If States want to continue to receive billions of Federal dollars, they need to be held accountable for how these dollars are spent.

In our written testimony we have specific recommendations for preserving the Medicaid partnership and protecting beneficiaries. We also identify a series of questions about Medicaid restructuring that we believe need to be addressed before legislation is enacted.

Mr. Chairman and members of the committee, AARP appreciates the opportunity to testify today. The current Medicaid program can be improved but I ask you to be very cautious in your approach. Health coverage for millions of low-income elderly Americans and the Nation's only long-term care safety net are at stake.

Thank you.

[The prepared statement of Beatrice Braun follows:]

PREPARED STATEMENT OF BEATRICE BRAUN, BOARD MEMBER, AMERICAN ASSOCIATION OF RETIRED PERSONS

Mr. Chairman and members of the Committee, I am Beatrice Braun from Spring Hill, Florida. I am a member of the Board of Directors for the American Association of Retired Persons (AARP). Thank you for inviting me to testify today about the future of Medicaid and the effect that the proposed federal changes could have on older Americans.

You asked me to focus my testimony on what Medicaid means to low-income elderly beneficiaries because others will testify on behalf of children and the non-elderly disabled. Let me say, however, that AARP continues to be extremely concerned about the future of Medicaid as it affects younger generations. In the past decade, we have been very supportive of bipartisan measures to extend Medicaid coverage to low-income children and pregnant women at a time when many employers have dropped health coverage for employees and their dependents. Now Medic-

aid covers 15 million children, almost 60 percent of whom have at least one parent in the work force.

AARP has historically supported Medicaid savings measures when they have not harmed beneficiaries. We believe that the measures enacted in recent years to limit states' ability to "game" federal matching payments have helped constrain Medicaid's expenditure growth and preserve the federal-state partnership. We supported the bipartisan prescription drug rebates that resulted in millions of dollars in Medicaid savings.

At the state level, AARP volunteers have worked with officials in Vermont, Minnesota, Florida, Tennessee, Oregon, and Missouri to develop major changes in their Medicaid programs, and we continue to be involved in implementation. In other states, including New York, New Jersey, and Texas, AARP volunteers have been actively involved in Medicaid budget discussions with legislators and administrators to help protect vulnerable Medicaid beneficiaries. In all these state efforts, AARP volunteers are particularly concerned with maintaining and improving consumer protections for all low-income populations. We have seen firsthand how states can expand coverage and re-organize the delivery of care, but we also understand how important federal protections are in that process.

Thirty years ago, Medicaid was enacted as a *partnership* between federal and state governments to serve the country's most vulnerable populations. Medicaid was also created as an essential part of what Representative Wilbur Mills called "a three-layer cake"—Medicare Part A, Medicare Part B, and Medicaid. As we celebrate *Medicare's* 30th birthday and what that program has achieved, we should remember that *Medicaid* has also been enormously successful in expanding access to health and long-term care. For low-income older Americans who cannot afford Medicare's premiums and cost-sharing, Medicaid fills in the gaps. Medicaid also pays for prescription drugs and other benefits that Medicare does not cover but low-income seniors cannot afford. And Medicaid is the *only* long-term care safety net for frail, elderly people who need home care or who have to enter a nursing home.

We know that this Committee faces a difficult task in reforming Medicaid and coming up with $182 billion in Medicaid budget savings. In fact, we believe that the Medicaid reductions are so large that they will directly harm Medicaid beneficiaries, and that the number of uninsured Americans will increase more dramatically. We also believe that simply boxing up Medicaid's problems and shipping them to the states as a block grant will not work.

We are pleased that the Committee has held several hearings to identify the shortcomings of the current Medicaid program, but there remain fundamental unanswered questions about how the proposed budget savings could be achieved and what effect major restructuring of Medicaid will have on low-income Americans. We are also very concerned that the budget schedule is so tight that the Committee will not have adequate time for public debate on the specifics of your Medicaid proposal before decisions are made.

A recent study by The Urban Institute estimates that in the year 2002 the Medicaid budget cuts could result in *8.8 million low-income Americans* not receiving Medicaid coverage. Even this estimate assumes that states will be able to hold growth in Medicaid costs per person to below what the private sector has achieved. The Urban Institute study also projects that in the year 2002, as a result of the proposed budget cuts, Medicaid spending for long-term care could be $29 billion less than is currently projected for that year. Researchers at The Urban Institute and Lewin-VHI point out that states will be limited in their ability to achieve savings through. managed care or reductions in provider payments for acute care services.

The combination of Medicare *and* Medicaid cuts—$452 billion over the next seven years and nearly half of the proposed total deficit reduction—would force older Americans to pay more and get less care. In many instances, access to care could be denied altogether. Recent research conducted for AARP by DYG, Inc. found that 88 percent of the public believe that without Medicare, older Americans would have to rely on programs like Medicaid. And 66 percent of the public believe that without Medicare, older Americans would have to rely on their children or other family members to cover their medical expenses.

Block Grants Would Greatly Weaken The Federal-State Partnership

Virtually everyone agrees that there are substantial opportunities to simplify the Medicaid program and make coverage more rational. In many instances, states have wanted to move ahead with innovative approaches. Although we believe that states already have a great deal of flexibility in the Medicaid program, we support even greater flexibility when it would expand coverage, improve services, or contain costs without jeopardizing access or quality. For example, states need additional flexibility to establish and expand much-needed home and community-based care programs

as an alternative to nursing home care. Specifically, states should be able to experiment with managed care in this area with programs like the Program of All-inclusive Care for the Elderly (PACE). Furthermore, the current linkage between eligibility for nursing home care and home and community-based care should be eliminated. States also need greater flexibility to pay providers at a level that contains costs but also assures access and quality. Moreover, states should be allowed to streamline the currently cumbersome eligibility process and to enable individuals to be eligible for Medicaid without being on income maintenance programs like AFDC or SSI.

Some greater state flexibility could help Medicaid—but **block grants, like the proposed reductions, go too far.** The budget proposal to block grant Medicaid *jeopardizes important federal consumer protections* designed to help older Americans. It jeopardizes the health and safety of the oldest and most vulnerable, those—primarily women—in nursing homes.

Block Grants and Cuts Would Hurt Medicare Beneficiaries Who Need Medicaid To Pay For Prescription Drugs and Other Services That Medicare Does Not Cover

Medicare beneficiaries who also qualify for full Medicaid coverage cannot afford the high costs of prescription drugs, mental health care, preventive and other services that Medicare does not cover. The proposed Medicaid budget reductions and block grants could result in these important benefits being eliminated for many low-income older Americans who need them. The proposal might also allow states to mandate that low-income Medicare beneficiaries give up their Medicare-protected choice of provider. AARP believes that managed care should be an option, but we oppose forcing Medicare beneficiaries into HMOs or other restricted-choice plans. Furthermore, to date, states have had very little experience in managed care for elderly populations and should move slowly in this area.

Block Grants and Cuts Could Eliminate Protections for Qualified Medicare Beneficiaries (QMBs)—A block grant could allow states to eliminate the QMB program entirely, leaving vulnerable, low-income seniors without the ability to afford even the most basic Medicare services. Under current federal law, Medicaid pays the Medicare premiums, deductibles and coinsurance for beneficiaries with incomes below the federal poverty line (about $7,500 for singles and $10,000 for couples in 1993), and Medicaid pays the Medicare premiums only for Medicare beneficiaries with incomes between 100 and 120 percent of poverty. The QMB program was enacted in 1988, in response to the fact that these low-income persons simply **could not afford** to pay these amounts out-of-pocket and, therefore, were at serious risk of going without needed services.

Earlier this year, the National Governors' Association clearly indicated state opposition to the current QMB program. Its resolution (12.2.7) stated:

> Since the passage of the Medicare Catastrophic legislation in 1988, the federal government has increasingly passed on to the states the responsibility to protect low-income Medicare beneficiaries (e.g., the Qualified Medicare Beneficiary program). The Medicare program is a federal program and the federal government should bear all of its costs.

Under a Medicaid block grant, governors would be unlikely to dedicate adequate state funds to maintain the QMB program. One proposal that deserves review would be to alleviate the pressure on states by federalizing the QMB program. Serious questions remain, however, about how these new federal costs would be met. And on this point we would offer one caution—that costs shifted from Medicaid to Medicare ought not to be paid for through additional Medicare reductions. The proposed $270 billion in Medicare savings is already dangerously high and would harm Medicare beneficiaries.

One way to illustrate the importance of the QMB program is to look at a hypothetical, yet typical, low-income older couple. Let us assume that Mr. and Mrs. Jones are on Medicare, have a combined income of $9,000, and Mrs. Jones gets sick and needs hospital care. The QMB program would pay Medicare's premiums, coinsurance and deductibles, permitting the couple to spend their limited income on other basic necessities, including dental care (about $250 per year, on average, for the couple), needed prescription drugs (about $500 per year, on average, for the couple) and other services not covered by Medicare.

Without the QMB program, the couple would also have to pay: about $1,100 per year in Medicare premiums; a $716 hospital deductible; $200 in deductibles for physician care; and coinsurance for physician care averaging about $650 per year for the couple. If drugs and dental care are included, this means that, **without the QMB program, the Jones family would have to pay approximately $3,400 out-of-pocket to receive the health care they need.** This would leave them with only about *$5,600 per year to live on.* Is this a fair way to reduce the deficit? How

could a couple live on a monthly income of less than $500 per month? What would happen to Mrs. Jones if she could not pay these amounts? Would she still be able to receive some help from Medicaid?

Proposed Medicaid Reductions Threaten the Long-Term Care Safety Net

Medicaid is most Americans' sole protection against the high costs of long-term care. Since long-term care costs are so high (averaging about $38,000 per year for nursing home care and $50 to $200 per visit for home care), most older people cannot afford nursing home or home health services without some form of assistance. About 32 percent of Medicaid spending goes for long-term care, and Medicaid pays for more than one-half of the nation's nursing home costs.

However, not all older individuals are poor enough to qualify for Medicaid when they first need long-term care. Many who need long-term care start off as taxpaying, middle class Americans. When chronic illness strikes, they must "spend down" their life savings before they are eligible for the Medicaid long-term care safety net. Medicaid is the payer of last resort for persons who have no other way to finance the long-term care they need.

Under the Budget Resolution proposal, many older Americans would likely lose coverage for needed long-term care services. In the year 2002, according to estimates by Lewin-VHI, **over 2 million Americans could lose their Medicaid coverage & long-term care** as a result of the proposed Medicaid reductions. While this is only one possible scenario, we believe that it needs to be taken very seriously, particularly given the limited range of options for any other significant long-term care savings needed to achieve the targets proposed. For example, changes in the Boren amendment or experimentation with managed care are not likely to achieve significant long-term care savings. Although we believe that states should have greater flexibility to experiment with capitated payment options for long-term care such as PACE programs, there is no reliable evidence that such programs will result in substantial savings, particularly in the short term since start-up costs tend to be high.

It is also important to bear in mind that Medicaid *currently* leaves many frail elderly people without the long-term care that they need. In many states, for example, waiting lists for home care services are very long. Reducing the financial support for beneficiaries who need home care services will likely have a devastating impact on millions of families.

Unfortunately, Medicaid spending on long-term care in the home and in the community is very limited. Spending for Medicaid-financed home care services accounted for only 16 percent of Medicaid spending on long-term care in 1993. In part, this is due to the fact that the nursing home industry is far stronger than home care advocates in most state legislatures. These political realities raise concerns that, under a block grant, home and community-based services will not receive the attention and support they deserve.

Proposed Block Grants Threaten Essential Consumer Protections

Nursing Home Spousal Impoverishment Protections—A block grant could allow states to eliminate current spousal impoverishment protections. Financial protections for spouses of nursing home residents were enacted in 1988 because spouses who remained in the community were often left without income and savings to survive on as their wives or husbands entered a nursing home and the couple spent-down to Medicaid eligibility. Prior to 1988, many couples had to spend virtually all of their life savings to qualify for Medicaid coverage. In some cases, the situation was causing couples married for 50 years to sue each other or get divorced to ensure that the spouse living in the community had the financial resources needed to live. The proposed Medicaid cuts could mean that in many states we will turn back the clock. Spouses who remain in the community might once again find themselves bankrupt and dependent on welfare because they cannot afford $40,000 a year to pay for the cost of nursing home care.

Protections for Beneficiaries Against Losing Their Homes—Current federal law does not count the value of a beneficiary's home in determining eligibility for Medicaid (unless the beneficiary is unable to return to the home) and prohibits the state from placing a lien on the home while the spouse is still living there. Under a block grant, states would likely be permitted to eliminate these protections, meaning that the nursing home residents and/or their spouses could be **forced to sell their home** in order to receive protection from the Medicaid program against the high cost of long-term care.

Nursing Home Quality Protections—A block grant could eliminate successful federal nursing home quality standards. A 1986 study by the widely respected, independent National Academy of Sciences Institute of Medicine concluded: "A stronger federal leadership role is essential for improving nursing home regulations because

not all state governments have been willing to regulate nursing homes adequately unless required to do so by the federal government." Landmark federal nursing home quality improvements were enacted in the following year. Repealing these quality protections would be a drastic step backward, and could **place millions of frail nursing home residents in jeopardy.**

Evidence demonstrates that the nursing home reform law has improved the quality of care in nursing homes. For example, one of the primary goals of the 1987 Nursing Home Reform law was to develop and enforce standards on the use of restraints. Far too many frail residents were being strapped to wheelchairs in an attempt to manage their care. According to a report by the Health Care Financing Administration (HCFA), between December 1989 and September 1991, the use of physical restraints **declined by over 41 percent.** Experts believe that this substantial improvement in the quality of the lives of the oldest and most vulnerable Americans can be traced directly to the nursing home provisions of the law enacted in 1987. A 1992 study by the Research Triangle Institute published in the American Journal of Public Health found that such reductions in the use of restraints also **reduce the cost of care.**

Abuse of nursing home patients was also targeted in the 1987 law. Guidelines developed by HCFA advising nursing home inspectors on how to interpret the law have produced a large increase in the number of nursing homes cited for patient abuse. In 1989, 1.2 percent of nursing homes were cited; in 1993, 11.8 percent of nursing homes (roughly 1,800-1,900 facilities) were cited. **Better inspections** as a result of the 1987 law resulted in *nearly a ten-fold increase* in the number of facilities caught and punished for abuse.

Preserving Medicaid's Federal-State Partnership

Many of the Federal Medicaid protections were enacted *because states were not doing enough voluntarily.* Absent federal requirements, there is little reason to be confident that all states will continue to provide them. If states want to receive billions and billions of federal dollars, they need to be held accountable for how they spend them. Therefore, we believe that, in order to continue to receive these diminishing federal taxpayer dollars, Congress should require that states meet certain minimum standards. While there may be ways to improve, simplify and streamline certain standards, eliminating them clearly is not the answer. Such an outcome would likely result in great harm to low-income Americans in need of health and long-term care in many states.

Specifically, we believe that Federal law should continue to govern in the following areas:

- Populations currently covered by the Medicaid program should be protected.
- States should be required to provide a defined minimum set of services, including hospital and physician services, prescription drugs, mental health care, and nursing home and home and community-based care.
- States should continue to be responsible for matching federal Medicaid dollars at roughly the current average 43 percent level. With more than 40 million Americans without health coverage and substantial unmet long-term care needs, it would not make sense to reduce states' share of Medicaid spending.
- States should not be penalized for anticipated growth in their low-income populations, or unanticipated growth due to downturns in the economy.
- The federal government should closely monitor state Medicaid programs, collecting important financial and program information to ensure that federal Medicaid dollars are being spent appropriately.
- States and the federal government should ensure meaningful public participation in major Medicaid decisions that will affect the 36 million low-income Americans who rely on the program.

Remaining Questions About Medicaid Block Grants

While the general approach to achieving $182 billion in Medicaid reductions was outlined in the budget resolution, there remain a number of major questions:

- Will low-income Medicare beneficiaries be protected against the likely increases in Medicare premiums, deductibles, and coinsurance; and what role will Medicaid play?
- Will states be limited in how severely they can cut Medicaid eligibility to make up for reductions in federal Medicaid spending, particularly if measures such as expanded managed care do not produce the expected savings?
- Will there be close federal monitoring of the proposed Medicaid changes that will trigger expedited consideration by the Congress if the new approach is not working?

- Will states that have engaged in questionable financing practices get to keep these federal dollars at the expense of states that followed the letter and spirit of the federal-state financial partnership?

Mr. Chairman and members of the Committee, I appreciate the opportunity to testify today on behalf of the 5 million older Americans who rely on Medicaid. The current program needs change, but I ask you to be cautious in your approach because millions of low-income Americans as well as the entire long-term care safety net is at stake.

Mr. BILIRAKIS. Thank you, Ms. Braun and a belated welcome to Washington. I am sorry it is so hot for you. It is probably hotter than it is down there.

Ms. BRAUN. It's hot down there.

Mr. BILIRAKIS. I know, it's always hot down there.

Ms. Wcislo.

STATEMENT OF CELIA WCISLO

Ms. WCISLO. Mr. Chairman, members of the subcommittee, I am Celia Wcislo, President of Local 285 of the Service Employees International Union. With over 1.1 million members, SEIU is the third largest union in the AFL/CIO and the largest union of health care workers in this country.

My Massachusetts local includes the full range of care givers, workers in acute care hospitals, nursing homes, mental hospitals, community-based health clinics, schools and public health departments. On their behalf, I would like to thank you for the opportunity to testify today.

SEIU strongly opposes proposals to convert Medicaid from a Federal/State entitlement to a block grant and limiting its growth to 4 percent per year. Cuts of that magnitude will force States to pursue some combination of these three strategies:

First, States will limit the number of people eligible for the program. Second, States will cut payments to health care providers. And, last, States will eliminate some Medicaid benefits or services. I would like to walk through these likely State options and describe their consequences.

The first State strategy would be cutting the number of eligible recipients. Today, as employer-sponsored coverage continues to decline and with little hope of comprehensive health reform, Medicaid assumes a greater importance to covering American families. Many of those covered are working families whose employers do not provide coverage.

For example, SEIU represents close to 2,200 home care workers in Los Angeles County who rely on MediCal for their insurance. In Massachusetts as in the rest of the country, it guarantees thousands of low-income children access to care and pays for more than half of the nursing home care for our elderly.

Medicaid savings will not come merely by reducing how much we spend per capita. Studies show the States will be able to achieve at most half of the savings that you are asking for. In order to receive the remainder of the savings, Massachusetts would have to push close to 200,000 beneficiaries off the Medicaid rolls by the year 2002.

The situation would be even more extreme for places like Florida and Georgia, where Medicaid populations would have to be reduced by more than 25 percent under the House proposal. Massachusetts

worked hard to develop and win approval of Medicaid innovations that would both help control costs and expand coverage to thousands of uninsured residents. In Massachusetts, we faced hard choices. Do we provide more coverage for children or disabled adults? Do we provide coverage for the working poor or the unemployed poor? But at least we were able to expand coverage.

With the House proposal, the goals of expanding coverage will all but disappear. We will be left with only the hard choices. This is a giant step backward and we strongly urge you to preserve the entitlement.

The second State strategy will be cutting reimbursement to safety net providers. The Medicaid program is critical to the survival of Boston City Hospital. This hospital is the only publicly supported acute care institution in Boston that serves a growing number of uninsured Massachusetts as well as disproportionate number of Medicaid beneficiaries, high-risk individuals and other vulnerable patients. We are already trying to do more with less. Over the last 4 years, budget cuts have led the hospital to cut over 1,000 positions at the same time that the volume of services has increased by 16 percent.

Now, Boston City Hospital and Boston University Medical Center have voted to merge, a public and a private institution. To remain financially sound and carry out our public health mission, we require adequate Medicaid reimbursement including DSH payments that compensate the hospital for treating large numbers of uninsured and low-income patients. Block grants will not allow that financial base.

The third State strategy will be eliminating Medicaid services and regulations. One of the arguments for converting Medicaid to a block grant is that eliminating Federal regulations will give States the flexibility to experiment with new delivery systems and cost controls. SEIU believes that the potential savings from these have been vastly exaggerated. Current law has enabled Massachusetts to redesign its programs but the savings don't come close to what is needed under congressional proposals.

The risks to quality should not be overlooked as years of experience in nursing home care have shown us. As the single largest payer of long-term care services in the United States, Medicaid has played an important role in improving the quality of care for nursing home residents. In 1987, in response to widespread complaints, Congress passed significant nursing home reform amendments. Yet much remains to be done.

A recent study of nursing home conditions by Consumer Reports magazine found that many facilities ranged from inadequate to scandalous and the good ones are hard to find. Declining staffing levels is leading to an increased number of patient injuries and injury levels are up more than 50 percent when compared to a decade ago. It is more dangerous to be a nursing home worker than to be a coal miner today.

Block granting the programs would eliminate those standards on the States, bringing back to the Nation the days when abuse and profiteering were widespread and families feared placing their family members in a nursing home.

In conclusion, I would like to be very clear about my recommendations to the subcommittee. One, you must preserve the health care entitlement for millions of Americans. The day block grants take effect, millions of children, working families and elderly Americans will lose guaranteed health coverage.

Two, you must preserve Federal quality standards. You need more Federal leadership, not less. Finally, I remind you that health care savings often come back to haunt policymakers. Today's Medicare savings may well lead to tomorrow's health insurance premiums.

Thank you.

[The prepared statement of Celia Wcislo follows:]

PREPARED STATEMENT OF CELIA WCISLO, PRESIDENT, LOCAL 285, SERVICE EMPLOYEES INTERNATIONAL UNION, AFL-CIO, CLC

Mr. Chairman, members of the Committee, I am Celia Wcislo, President of Local 285 of the Service Employees International Union, AFL-CIO, CLC. With over 1.1 million members, SEIU is the third largest union in the AFL-CIO and the fastest growing. My own local in Massachusetts represents the full range of caregivers in the health care industry, including workers in nursing homes, hospitals, schools, health clinics, and public health departments. On their behalf, I would like to thank the Chairman and the other members of the subcommittee for this opportunity to testify today about the future of the Medicaid program.

Enacted in 1965 as a companion to Medicare, Medicaid provides health insurance coverage and long-term care services for over 32 million people. While the majority of those covered by Medicaid are low-income adults and children, two-thirds of program funds go to pay benefits for the elderly and disabled because of their intensive use of acute and long-term care services

Authorized under Title XIX of the Social Security Act, Medicaid is financed by state and federal funds and administered by the states in accordance with federal regulations. These regulations require states to cover certain categories of individuals and certain services, but states have the option of providing additional benefits and retain significant discretion in setting financial eligibility criteria. States that meet federal guidelines receive federal matching payments based on the state's per capita income. These payments range from 50 percent to 80 percent of a state's annual outlays.

This subcommittee is currently considering a proposal that would make radical changes in the Medicaid program as we have known it. The proposal would convert Medicaid from a federal-state entitlement program into a block grant. Annual increases in this block grant would be severely limited, falling to four percent by the year 2002, in order to achieve the $170 billion cut in federal Medicaid spending called for in the budget resolution. At the same time, states would be given unlimited discretion to set benefits and eligibility standards.

SEIU is strongly opposed to these changes in the program. We believe they will wreak devastation on beneficiaries, state and local governments, providers and health care workers. The remainder of our testimony outlines the likely impacts of implementing the proposed changes.

A Medicaid Block Grant Will Cost States Billions of Dollars

Federal Medicaid expenditures are projected to grow by $87 billion, or roughly 10 percent a year, over the 1996-2002 period. Under the budget resolution recently adopted by Congress, the rate of growth would be cut in half, carving just over $170 billion out of the program during this time period.

The impact on state budgets will be devastating. A recently released study from the Urban Institute found that, over the 1996-2002 period, states would see a cut of 18 percent in their federal Medicaid dollars. The cuts are distributed unevenly across states. Four states—California, Florida, New York, and Texas—will lose over $58 billion collectively, more than a third of the total cuts. Georgia, Illinois, North Carolina, Ohio, and Pennsylvania would also face large cuts of over $6 billion each between 1996 and 2002.

High-income states, e.g. Connecticut, New York and Massachusetts, that have historically spent more on Medicaid would see smaller cuts in percentage terms. Conversely, low-income states, such as Florida, West Virginia, North Carolina, and Georgia, would see much larger cuts in percentage terms.

The impact of these cuts would be exacerbated if the Medicaid program is converted into a block grant. The advantage of the current Medicaid formula is that it can respond quickly to change. If a state's Medicaid population grows because of population growth or recession, more federal matching dollars become available. If a state's per capita income falls because of tough economic times, the federal share is increased.

A block grant, however, would eliminate this system, freezing into place large disparities in federal payments to states. These disparities could be exacerbated by different rates of population growth. There are at least ten states whose population is expected to grow by 8 percent or more between 1995 and 2000, while eight states are projected to grow by less than 1 percent or experience a population decline.

Changes in state economic conditions could be more significant than population growth in determining whether a state's allotment was sufficient to cover the costs of providing health insurance to needy families. Over a five year period, the effect of a recession may be far more dramatic than the effect of population growth. For example, from 1989 to 1993, the nation's population grew by 4.5 percent. During that same period, the number of unemployed persons increased by 35 percent and the number of Medicaid beneficiaries increased by 41 percent. A population adjustor would have done little to address the caseload increase during a recession.

States will find it impossible to absorb cuts of this magnitude without making significant cuts in eligibility, benefits or payments to providers. The CBO baseline for the next seven years already assumes that much of the Medicaid population will be enrolled in managed care by the end of that period, so states will have to find large savings elsewhere. While long-term care has largely remained outside of managed care, the potential for savings is not large. Wage rates for nursing home and home care workers are at poverty levels and most nursing homes are significantly understaffed already. Any fat in the Medicaid program has long since been eliminated. These new cuts would slice away muscle and bone.

An Additional Nine Million People Will Lose Eligibility for Medicaid

As the number of people covered by employer-sponsored health insurance continues to decline, Medicaid is assuming greater importance as a provider of health insurance to more Americans. Between 1988 and 1994, the share of those under the age of 65 covered by employer-sponsored health insurance fell from 67 percent to 61 percent, while the share covered by Medicaid rose from 9 percent to 13 percent.

Many of those covered by recent expansions in Medicaid are workers with families whose employers do not provide health insurance coverage. For example, SEIU represents over 2,200 home care workers in Los Angeles County who rely on Medi-Cal for their insurance.

Medicaid is particularly important to women and children, because employer-sponsored coverage for dependents has fallen dramatically since the late 1980s. Nearly one-third of all births are now paid for by Medicaid and in some states the program pays for almost half. Medicaid currently covers 18 million children—one quarter of those under the age of 21 and one-third under the age of 6. Past Congressional action guarantees that every poor child under 18 will be covered by the year 2002.

The reductions in funding contemplated in the budget resolution could undo the progress we have made and leave million of Americans, especially children, with no health insurance. The Urban Institute has estimated that enrolling beneficiaries in managed care, reducing covered services, and cutting provider payments would only pay for about half the cuts contemplated in the budget resolution.

The remaining savings would have to come from eliminating insurance coverage. The Urban Institute estimated that by 2002 there would be 8.8 million fewer individuals eligible for Medicaid than under than current policy, including 6.3 million parents and their children. An additional 1.4 million disabled and 920,000 elderly also would become ineligible for Medicaid services.

A few states would be particularly hard hit. In 2002, Florida, Georgia, Virginia and West Virginia would all see a fall of over 25 percent in the number of individuals covered by Medicaid, relative to the current baseline. Overall, enrollment reductions are likely to be greater in the south and mountain states.

In many cases, we can expect states to cut eligibility by reducing coverage for certain benefits. In New York, where SEIU represents 23,000 home care workers, Governor Pataki's recent budget proposal would have cut Medicaid by $1.2 billion through a combination of cuts in eligibility, benefits, and payments to providers, especially in home health. Among the cuts were the elimination of home health coverage for 500,000 adults, elimination of the Long Term Home Health Program, elimination of the Assisted Living Program, elimination of coverage for basic household tasks, and limiting personal care hours to 100 a month. Eliminating home

health is likely to be a particularly tempting target because it would be politically difficult to eliminate coverage for residents of nursing homes.

Cuts Would Devastate Safety Net Providers

The proposed Medicaid cuts would also have a devastating impact on safety net providers, particularly public hospitals, community health centers, children's hospitals, and rural clinics. Despite differences in size, structure and services, these providers share two basic missions: to furnish comprehensive health care to uninsured and medically underserved persons and to provide a range of important primary and specialized services to the entire community. Both of these missions would be jeopardized if the proposed cuts in Medicaid are implemented.

Medicaid is the single most important source of revenue for these safety net providers. Medicaid pays for half of all outpatient days and over a third of all inpatient days in public hospitals, and for almost half of the care provided in children's hospitals. More than one-third of community health center patients and slightly less than a third of rural health clinic patients are insured by Medicaid.

Revenue from Medicaid and local governments helps public hospitals provide services to the growing number of uninsured in the United States. In Los Angeles County, where SEIU Local 660 represents the county employees, a single hospital, LAC-USC Medical Center, provides 70 percent of all inpatient care to the uninsured, with the other five county hospitals accounting for most of the rest. Only one to two percent of care to the uninsured in the county is provided by private hospitals.

I know how important the Medicaid program is to Boston City Hospital, where Local 285 represents 2,200 of the 5,500 unionized healthcare workers. BCH is the only publicly supported acute care institution in Boston and offers nationally recognized treatment programs in areas such as AIDS, arthritis, diabetes, developmental pediatrics, hypertension, and sickle cell anemia to name just a few. The hospital has Level One adult and pediatric trauma centers, and handles two-thirds of all Boston's trauma cases. Over the last four years, budget cuts have led the hospital to cut over 1,000 positions at the same time that the volume of services delivered increased by 16 percent.

BCH and the nearby Boston University Hospital recently voted to merge, creating the New Boston Medical Center. We all hope that this new institution will be able to better serve the needs of our low-income and uninsured patients. I am concerned about the impact that the proposed cuts will have on our ability to carry out our public health mission. Prior to the merger, Medicaid paid for almost one-third of BCH's patient days and Medicaid will pay for a little over one-fifth of the patient days for the new merged entity.

However, this understates the importance of Medicaid because BCH receives Medicaid Disproportionate Share Hospital (DSH) payments that compensate the hospital for treating large numbers of uninsured and low-income patients. In the last few years, DSH payments have become a lifeline to safety net providers. A survey by the National Association of Public Hospitals recently showed that the major urban public hospitals collect almost as much in DSH payments as they do in local subsidies. DSH payments account for about 28 percent of total net Medicaid revenues and 12 percent of total net revenues. Most high-volume safety net providers simply could not survive without these payments, especially with universal coverage no longer on the national horizon.

I am concerned that the proposed cuts in Medicaid will put our newly merged hospital in a vise. On one side, there will be the pressure of a growing number of uninsured patients who will be coming through our doors because of the cuts in Medicaid eligibility. At the same time that we will be asked to do more, we will be given fewer resources because reimbursement payments and DSH payments will also be cut. This will make it harder to us to carry out our mission to serve the poor and uninsured in the City of Boston.

By Eliminating Federal Regulations, A Medicaid Block Grant Puts Beneficiaries at Risk

One of the arguments for converting Medicaid into a block grant is that eliminating federal regulations will give states the flexibility to experiment with new delivery systems and cost control policies. SEIU believes that the potential savings from this have been vastly exaggerated and the potential risks overlooked.

Allowing states to have complete discretion in designing their benefit package will merely lead to a race to the bottom as each state seeks to avoid providing fewer services than its neighbors in an effort to keep the sick and the poor away. Potentially arbitrary decisions by states to eliminate a particular service or benefit, such as limiting the number of physician visits or screenings for children to identify medical problems early or eliminating services by community health centers, have the

potential of denying access to many low-income families as well as forcing families to delay needed care. The result will be higher costs, as many will end up in hospital emergency rooms. Furthermore, many of the optional services states currently cover such as prescription drugs or translation services could be eliminated

Because it is the single largest payor of long-term care services in the United States, the Medicaid program has also played an important role in maintaining and improving the quality of care for nursing home residents. In 1987 the Nursing Home Reform Amendments to the Omnibus Budget Reconciliation Act of 1987 (OBRA 87) were passed in response to widespread complaints about the quality of care in nursing homes. OBRA '87 requires nursing facilities to assess a resident's condition, develop a plan of care, and meet certain minimum staffing requirements.

While these regulations have brought improvements to many nursing homes—such as limiting the use of resident restraints, improving the treatment of bedsores, and requiring training and certification for nursing assistants—much remains to be done and adequate enforcement remains a problem. A recent study of nursing home conditions by *Consumer Reports* magazine found that "many facilities range from inadequate to scandalous and the good ones are hard to find."

With 100,000 SEIU members employed in nursing homes, the results of the Consumer Reports study came as no surprise to us. Our members report that while many nursing homes are admitting sicker residents in an attempt to corner to lucrative "sub acute" market, staffing levels are flat or declining. This is leading to an increased number of patient falls and other patient injuries. It is also putting nursing home workers at risk, with injury levels up more than 50 percent when compared with a decade ago. Nursing home workers currently have a higher injury rate than coal miners, construction workers, steelworkers, or truck drivers.

Block granting the program would eliminate all the standards and requirements on states to ensure that the quality of care is enforced in long term care facilities. It will put millions of nursing home residents and the workers who care for them at serious risk of illness and injury. It could bring the nation back to the days where abuse and profiteering were widespread and families feared placing their family member in a nursing home.

There are avenues within the current Medicaid program for added state flexibility. A number of states have already applied for Section 1115 and Section 1915b waivers to restructure their Medicaid programs, and the Clinton Administration has already approved many of them. While there is room for streamlining, the negotiations between the states and the Administration have assured that access to services, quality of care, and other protections for beneficiaries are maintained. For states that are serious about redesigning the program in ways that benefit the poor and uninsured, the barriers to doing so are not significant. Congress should continue the practice of allowing states to experiment within boundaries set by the federal government.

Understaffing is Threatening the Quality of Care and Medicaid Cuts Will Make it Worse

The health care industry could respond to deep Medicaid cuts by further cutting staffing levels. Already, patient loads are 50 percent higher than they should be, nurses don't have enough time to spend with their patients, and accidents and medication errors are on the rise. SEIU nurse members working in the emergency room at the Los Angeles County-University of Southern California Medical Center report chronic understaffing. Often there are only six nurses on duty in the ER, even though the hospital's staffing plan requires a minimum of 10 nurses per shift. Because of staffing problems, the ER is often closed to transfers and paramedic runs are diverted elsewhere.

Understaffing has real consequences for the quality of patient care. A rash of high profile clinical errors in hospitals across the United States has captured the attention of the media and the general public. What is less well known is the role that understaffing played in many of these cases.

One incident that attracted a great deal of attention was the amputation of the wrong leg of a 51-year old diabetic patient, Willie King, at University Hospital in Tampa, Florida. After this story came to light, two other incidents were subsequently revealed. A 77-year old male patient died on March 3, after his respirator was mistakenly removed, and arthroscopic surgery was performed on the wrong knee of a female patient on February 13. According to published reports by the Associated Press and the *St. Petersburg Times*, state and federal investigators have cited staffing problems, including assigning staff with minimal training to treat critically ill patients and overloading nurse supervisors with other jobs that left them unable to supervise, as factors that contributed to these errors.

Stories like this are likely to proliferate if Medicaid is slashed by the huge amount called for in the budget resolution. Frontline caregivers are already stretched to the limit, continually being asked to do more with less. There comes a point where you simply cannot do more with less. In the Medicaid program, that point has already been reached.

Conclusion

Since its enactment in 1965, Medicaid has improved access to health care for the poor, pioneered innovations in health care delivery and community based long-term care services, and stood alone as the primary source of financial assistance for long-term care. Medicaid has been consistently shown to improve access to health care for the population it serves.

SEIU recognizes that Medicaid has become a major budgetary commitment for both the federal and state governments. In recent years, Medicaid expenditures have escalated rapidly. The rise in spending was attributable to a combination of health care inflation, increases in state use of alternative financing mechanisms such as provider taxes and donations, and a rise in enrollment. Only a small fraction of spending growth was attributable to the expansions in coverage of low-income pregnant women and children.

SEIU's experience in negotiating and managing health benefit plans in the private sector suggests that there are innovative ways to reduce the rate of growth in Medicaid outlays that would not require converting the program into a block grant. The idea would be to turn Medicaid from a passive payer of bills into an active purchaser. This is the way that most private plan sponsors are moving. States are already experimenting with a number of approaches to controlling Medicaid costs, including managed care, case management, selective contracting, and improved enforcement against fraud and abuse.

In the end, the members of SEIU believe that reform of the Medicaid system should be linked to reform of the whole health care system. For years, the private sector has been allowed to insure the young, the healthy, and the financially secure, whereas the public sector has been left with the job of insuring the elderly, the sick, and the poor. Although costs have risen for the private and public sectors alike, the burden of public sector programs has been especially heavy of late, and threatens to bankrupt federal, state, and local governments and drive costs even higher for working families.

What is needed is *system-wide* cost control that should be implemented as part of a comprehensive health care reform program that provides universal health insurance coverage to all Americans. Absent these comprehensive reforms, the Medicaid program must be preserved as an entitlement program. Given national health objectives, states should be allowed to experiment, but only within guidelines set by the federal government.

Mr. BILIRAKIS. Thank you, Ms. Wcislo. They do come back to haunt us quite often.

Ms. Gannoe.

STATEMENT OF KATHLEEN GANNOE

Ms. GANNOE. Mr. Chairman and members of the committee, I thank you for the opportunity to provide testimony on behalf of the National Citizens Coalition for Nursing Home Reform, where I serve as a Vice President of the Board of Directors.

In my real life, I am an advocate for nursing home residents in the Lexington, Kentucky, area.

The coalition is the only national organization that represents the interests of nursing home residents across the country and we are a coalition of family groups, of resident groups and of advocacy groups who are interested in the lives and quality of care for nursing home residents.

Earlier this morning, Representative Coburn wanted to know what had been done right and I want to tell you that you all have done right in the past. This Congress and this committee have done good things about nursing home reform and I really want to talk to you about the good stuff that has been done.

The best thing that you all can look to in your history of what you have done is the Nursing Home Reform Law of 1987. Because of the high cost of nursing home care that everyone has already talked about and everyone has already talked about how folks end up on Medicaid particularly paying for their nursing home care, very few of us can sustain the $36,000 to $38,000 a year cost that it costs to be in a nursing home for the average of 2½ years of stay. So Medicaid right now assists 1.6 million folks in nursing homes out of 2 million. It provides matching costs for about 1.6 million people.

Converting to block grants is one of the notions that has been bandied around and it may be a good idea but the thing that worries us as advocates for nursing home residents is that there would be such wide discretion on delivering care that we are fearful that the good work that you all have done in the past would be lost. We are very concerned about losing the leverage of the Federal law and the Federal provisions for good care that would be lost if block grants go to the States without any provisions that are in the nursing home reform law.

That was a landmark achievement. There was some really horrendous testimony that you all had to listen to prior to the enactment of that law. There were stories that even today just really gives you pause listening to the kind of care that happened in nursing homes prior to the reform laws. Not all nursing homes, but in some. And I have to tell you from my own experience in Kentucky, I started as an ombudsman in 1984, and the stories that I worked with, the folks I worked with, the issues I worked with before the Nursing Home Reform Law were quite different from the ones that we worked with afterwards.

There were cases of abusive nursing assistants. We had this one gal who thought the way of handling a resident who called out for help was to stuff a wash rag in her mouth. And she was fired, rightly, from the nursing home for doing that with a couple of residents but went right down the road and got another job in another nursing home.

Now, it's a law that—of the Nursing Home Reform law, that abusive aides have to be put on a registry. Aides have to be trained and so they know that that is not the way to give good care and if they persist in giving that kind of care, they don't get hired again in nursing homes and that's good and that's in place now administration advocates fear that without that kind of provisions and those kinds of protections for residents, those bad old days will come back.

Congress wanted the abuses stopped so you put in place these nursing home reform laws and the provisions in the law were things like residents needed to be assessed, nursing assistants had to be trained, there had to actually be nurses in nursing homes and that those nurses had to give a planned care, that there had to be a plan for how you would take care of folks and that the expectation of going into a nursing home would be that folks would get better or at least they would not decline because they were not given good care. And that's in place and that's working and I appeal to you as an advocate for the 5,078 residents in central Kentucky that I personally represented and all of the residents across

the country that I represent with the coalition that you all keep those provisions in place.

To tell you how they work, there is a resident in my area, in Winchester, Kentucky. This lady has Huntington's Disease, which is just dreadful, the impact on the resident is just dreadful and the nursing home was at their wits' end and was talking to the daughter about discharging her and the ombudsman and the family came together with the staff and we applied the principles that are in the good care in the Nursing Home Reform law, the principles of assessment, of bringing in outside consultants to help us in working out a plan of care and, above all, in giving this resident autonomy and choice in her own treatment and her own care and she is getting wonderful care today and she is involved in it.

I see I have a little, red light so let me tell you——

Mr. BILIRAKIS. Please summarize if you would like.

Ms. GANNOE. I am going to do that.

Taking care of folks before they get sicker is a whole lot cheaper than batting cleanup, is that the expression? It is better to prevent bed sores than to take care of bed sores. It is cheaper to walk people to the toilet than it is to keep them at $6 a day in incontinent briefs. And this is what the Nursing Home Reform law is guiding the long-term care industry to do. And we just really want you to be very, very careful when you look at all the possibilities for transforming the Medicaid program and remember the good work that you have done and keep it in place.

Thank you very much.

[The prepared statement of Kathleen Gannoe follows:]

PREPARED STATEMENT OF KATHLEEN GANNOE, VICE PRESIDENT, NATIONAL CITIZENS' COALITION FOR NURSING HOME REFORM

Mr. Chairman and Members of the Committee, thank you for the opportunity to present testimony on behalf of the National Citizens' Coalition for Nursing Home Reform. I am Kathleen Gannoe, Vice President of the Coalition's Board of Directors and Executive Director of the Nursing Home Ombudsman Agency of the Bluegrass in Lexington, Kentucky.

The Coalition, commonly known as NCCNHR, is the only national organization representing residents in nursing homes—members of the elderly population and younger people with physical disabilities or chronic illness who frequently are unable to speak for themselves due to the onset of debilitating infirmity or dysfunction. NCCNHR also represents residents' family members, as well as citizen groups and local, state and volunteer ombudsmen who form a nationwide network that helps to bring resident concerns to the attention of individuals entrusted to oversee public policy.

NCCNHR's mission is to improve the care and quality of life of all long-term care residents. More than 300 member groups and 1,000-plus individual members and subscribers from 42 states comprise this diverse, caring coalition. NCCNHR also houses the National Long-Term Care Ombudsman Resource Center, funded by the Administration on Aging. The Center provides technical support to local and state ombudsman programs in communities throughout the nation. My agency represents one of these programs. The long term care ombudsmen support residents when they encounter problems trying to secure appropriate care and treatment.

Congress has had a history of working with consumers, professionals, providers and regulators to ensure basic health and safety for vulnerable people in institutional and other long-term care settings. It is in that spirit of responsive, responsible government involvement that NCCNHR submits this testimony today.

Members of Congress have undertaken to balance the budget by 2002. This is a formidable challenge. At the same time, it offers important opportunities to look carefully at the entire long-term care system and find ways to develop a more integrated approach to care that includes, rather than sets apart, long term care.

In the mosaic of the nation's fragmented long-term care system, nursing home care depends most heavily on Medicaid—the subject of this hearing today. This testimony focuses on three issues: the adverse effects of Medicaid spending cuts on access to, and coverage of, nursing home care; the importance of preserving the 1987 Nursing Home Reform Act; and the high cost of poor care. NCCNHR brings these points to your attention with the hopes of developing a foundation of understanding that will lead to creative solutions, which meet both national interests and the needs of nursing home residents and their families.

I. MEDICAID IS A LIFELINE FOR NURSING HOME RESIDENTS

Because of the enormous cost of nursing home care, few people can pay privately for very long. Medicaid payments supplement the nursing home costs for about 1.6 million of the nearly two million people receiving nursing home care today. Older people and people with disabilities represent 30 percent of the Medicaid population. However, as many have noted amid the current Medicaid debate, older and disabled people account for 70 percent of total Medicaid expenditures due to the high cost of meeting their complex, chronic-care needs.

Many elderly Medicaid recipients are tax-paying citizens, who, before needing long term care, fell into the middle class. Like most of our parents and grandparents, they worked hard all their lives. Today's nursing home residents represent a generation of "savers." They are people who abhorred the idea of "going on the public dole." But when forced to cut corners, many scrimped on their own retirement savings, taking false comfort in the fact that Medicare would be there in their old age to protect them against financial disaster precipitated by long-term multiple disabling health problems. They never dreamed that nursing home care was not covered except under very limited post-hospitalization circumstances. Rare is the person—of any age—who understands that Medicare essentially covers only acute-care and not chronic-care services.

Future nursing home residents have not had the luxury of saving for their golden years, due to uncertain job markets, unaffordable private long-term care insurance, and the growing cost of home ownership, college tuition and other family expenses. Medicaid is the only federal program for people faced with the need for nursing home care but lacking the necessary funds to cover its catastrophic costs. Thus, the proposal in Congress to slow the growth of Medicaid by $182 billion over the next seven years would prove immensely harmful to vast numbers of citizens of all income ranges.

In 1994, 43 percent of nursing home residents relied on Medicaid to help pay for at least part of their care when they entered a facility. The rest of the Medicaid nursing home population entered a nursing home paying for their care, but eventually depleted all of their financial assets. In fact, one in four nursing home residents "spend down" (i.e., depleted their lifetime savings) within six months to one year after admission to a nursing home.

Medicaid recipients in nursing homes contribute all of their money toward the cost of their care. The only funds they may retain come in the form of a monthly "personal needs allowance," which, in 1994, ranged from a high of $75 in Alaska to a low of $30 in Tennessee and other states. The state average is $37.50. With a few exceptions, Medicaid payments supplement the difference between a resident's income and the cost of their care. If a nursing home's monthly rate is $3,200 and a person's monthly income is $2,800, Medicaid contributes $430 per month, thereby covering the difference and allocating $30 toward the resident's personal needs allowance—with the resident paying $2,800 toward the cost of her nursing home care.

The average daily rate for a semi-private nursing home room is more than $100, or about $38,000 annually. The cost of care is actually much higher in many urban areas. The length of the average nursing home stay is 2.5 years. How many among us could keep up with those costs for very long—much less more than two years?

Medicaid growth caps will further limit access to nursing home care

Access to nursing home care has always been difficult for people who depend on Medicaid. Higher paying private-pay residents receive preference in admission, thereby limiting entry to the most needy persons. These situations are not isolated incidents. Advocates from around the country receive calls daily about people being "shut out" or "dumped out" of nursing homes because they rely on Medicaid.

The proposed growth caps will increase the likelihood that a facility will try to discharge a resident who runs out of funds. This will happen for one of two reasons: Cuts in Medicaid spending will cause states to reduce their reimbursement to nursing homes, or to limit eligibility to fewer people.

Medicaid growth caps also will put increased pressure on states to limit the supply of nursing home beds, which currently have a 93-percent occupancy rate nationally. To control Medicaid budgets, states decrease the nursing home bed supply through a variety of measures, such as the state-run Certificate-of-Need programs. These programs effectively place a moratorium on the supply of nursing home beds. Congress in 1984 repealed the federal law mandating these programs, but they remain in existence in 44 states.

More than half of the Medicaid recipients admitted to a nursing home are transferred to a nursing home from another facility, most often a hospital. Thus, as the supply of nursing home beds drops, the duration of expensive hospital stays paid for by Medicare will rise. And, as people denied nursing home care are sent home without receiving proper services in the community, they are at risk of ending up back in the hospital—at Medicare's expense. Indeed, analysts predict that home and community-based care will be the first type of long-term care services that states will eliminate if they are faced with the proposed Medicaid growth caps.

It is important to note that quality of care decreases in relation to the supply of nursing home beds, as researchers indicated in a 1989 article in Health Services Research. As quality declines, the likelihood that a nursing home resident will require hospitalization increases, again forcing the federal government to subsidize the consequences of inappropriate care.

One important point on the issue of access to nursing home care cannot be overlooked. The proposed Medicaid growth caps will reach their zenith in 2002, as the elderly continue to reflect a larger sector of American society, with the number of people 85 years and over growing especially rapidly. These "oldest old" are the most likely to need nursing home care. The proposed growth caps do not take into account the U.S. Census Bureau's projection that this age cohort will "explode" over the next 15 years.

Access to nursing home care is an issue that touches every American family. Close to half (43 percent) of the people who reach 65 years will spend time in a nursing home at some point in their lives. By 2030, some 4.3 million people will need nursing home care. This estimate is more than double the number of people in nursing homes today, as researchers reported in a 1992 article published in the *Millbank Quarterly*.

In seeking to protect nursing home residents from the magnitude of the proposed Medicaid growth caps, NCCNHR wishes to draw your attention to the widespread occurrence of health-care fraud and abuse, as highlighted by Sen. William Cohen (R-Maine) in his 1994 report, *Gaming the Health Care System*. Sen. Cohen, who chairs the Senate Special Committee on Aging, and his staff reported that fraud and abuse cost Medicare and Medicaid more than $31 billion each year. Although there is no specific documentation on the total amount attributable to nursing homes, case examples in the report cited a number of long-term care "scams," including the dispersion of large quantities of sample and expired drugs to nursing home residents without their knowledge. Another example involved nursing home operators who charged swimming pools, the family nanny and other personal items to Medicaid cost reports.

NCCNHR understands the need to control government spending by looking carefully at the Medicaid program. But, Medicaid growth caps must not occur on the backs of citizens who are the least able to bear this additional hardship: frail older people, person small children. Instead, efforts to balance the budget should reflect a burden shared equitably by all sectors of society. It is incumbent upon all of us—consumers, professionals, providers and members of Congress—to meet this important challenge with full acceptance of the long-range human and fiscal consequences of the actions we take today.

II. BLOCK GRANTS THREATEN QUALITY STANDARDS FOR NURSING HOME RESIDENTS

Converting to block grants is one method that has been proposed as a route to achieve the Medicaid growth caps recommended in Congress's budget resolution. It is our understanding that the proposed block grant system would give states wide discretion over who receives services, and how services are delivered. Losing federal leverage over the financing of the Medicaid program will destroy the quality standards in the 1987 Nursing Home Reform Act. Moreover, observers of the current Medicaid debate predict that states will not accept such a significant reduction in federal support unless Congress repeals the rules in Title XX of the Social Security Act, where the provisions under the Nursing Home Reform Act are found. Thus, moves toward restructuring Medicaid has raised serious concerns among those familiar with the history of U.S. nursing homes.

NCCNHR formed in response to a persistent, sordid pattern of poor care in nursing homes in state after state. Citizen groups advocating quality nursing home care developed across the country, and, in 1975, joined forces under the umbrella of NCCNHR. Together, they turned to the federal government for support in improving the quality of care and making states more responsive to the rights and care needs of residents. Their efforts culminated with the passage of the 1987 Nursing Home Reform Act. Voted out in Congress with bipartisan support, the Nursing Home Reform Act stands as a landmark in the long struggle to increase quality in nursing homes.

A review of the history of the Nursing Home Reform Act is instructive and revealing amid current proposals to turn control of nursing homes back to the states. Therefore, Mr. Chairman, I would like permission to submit for the record a detailed history of the Nursing Home Reform Act.

By 1950, the federal government was already paying about half of the country's nursing home costs. Mounting concerns about poor care prompted the federal government to require states to develop licensing programs for nursing facilities. Still, state and federal commissions alike in the mid-fifties found low standards of care and poorly trained staff remained widespread in facilities. In the early sixties, Congress discovered enormous variation in both states' nursing home standards and their enforcement of those standards.

The number of nursing homes escalated sharply in the late sixties and seventies, in response to the growing need for nursing home care. Standards for facilities participating in the Medicaid program remained under states' jurisdiction. Lax enforcement of these standards rendered residents the victims of what Congress called "a litany of abuse"—unsanitary facilities, bodily harm, theft, and gross misuse of tranquilizers and other drugs. Still, the nations' nursing homes were receiving billions in taxpayer dollars—in the absence of neither uniform protections for residents nor effective enforcement of existing standards. As one witness described during a 1974 congressional hearing titled *Nursing Home Care in the United States: Failure in Public Policy:*

> He was not incontinent when he came. He had no problem urinating, he just needed some assistance walking to the bathroom. One day the day shift decided to catheterize him anyway... The first catheter drew blood instead of urine.... So he tried another one.... Later on that evening a clot came through his penis that filled the whole bottom of the bedpan. Two or three days later he was sent to the hospital He died there.

Another witness testified:

> One of the patients there was a retired dentist whose name I do not remember. His wife was dead and he had no relatives or friends that I know of. He had been treated for a bed sore by a heat lamp. Whoever had put the heat lamp on him had forgotten about it and just left it there. When I came on duty I had to treat him, and he had third-degree burns on his back.

Again, Mr. Chairman, I would like to ask that we include for the record a listing of key congressional hearings from this period.

In 1983, forty national citizens groups endorsed a Consumer Statement of Principles for nursing home regulatory and federal certification systems. Their statement preceded a comprehensive study of U.S. nursing homes, undertaken by the Institute of Medicine (IOM) at the National Academy of Sciences, by the direction of Congress. The IOM's 1986 report of that study, Improving the Quality of Care in Nursing Homes, became a blueprint for federal nursing home reforms, laying the principles for the Nursing Home Reform Act passed one year later.

The Nursing Home Reform Act has brought dramatic improvements in quality of life and care for nursing home residents

The Nursing Home Reform Act reflects several years of cooperative efforts on the part of many participants—consumers, professionals, health care providers, state and federal regulators, members of Congress and their staff, and leaders in the aging network.

The Nursing Home Reform Act commonly is described as "resident-centered." That simply means it focuses not on organizational structures or building codes, but on the actual delivery of care that meets each resident's individual needs. Under the law, these care practices must help to maintain or improve each resident's health and well-being. And they must be delivered in a setting that respects people's rights and dignity. It sounds simple, but it has led to dramatic improvements in care.

The key elements of the Nursing Home Reform Act include:

- Individualized assessment of each resident's abilities and needs.

- A plan of care, with specific goals, methods and measurements addressing residents' needs.
- A standard of care that supports the physical, mental and psychosocial well-being of each resident through supportive care, therapy, and resident and family participation.
- A standard for quality of life for each resident that provides for reasonable accommodation of individual needs and preferences.
- Protection of residents' rights to dignity and security, and freedom from abuse, restraints, and involuntary transfers and discharges.
- Training for nurse aides who deliver 90 percent of the care and attention to residents.
- Resident access to the long-term care omubdsman program for assistance when problems arise.
- Enforcement of standards through effective survey procedures that review the care from the resident's point of view, identify problems, assure correction and apply appropriate penalties.

The Nursing Home Reform Act provides a framework for facilities to help each resident reach his or her "highest practicable physical, mental, and psychosocial well-being." What does this language mean? Here is how one health-care professional explained it in real-life terms:

> These federal mandates...have changed the focus from "going somewhere to die," to "what is the best way (or ways) to care for this person to make him or her as independent as possible, or as comfortable as possible, or as content as possible." We don't drug residents into a stupor as much. There is more rehabilitative therapy, better and safer nursing, more activities. Most important, there is more stress on each person as an individual, making the nursing home adjust to the individual, instead of treating each person as "just another older person."—*Naomi Segal, hospital social worker, Philadelphia, PA.*

The Nursing Home Reform Act also steers facilities toward treating nursing home residents "in such a manner and in such an environment as will promote maintenance of quality of life with reasonable accommodation for individual needs and preferences." As one nursing home administrator has observed:

> The Reform Law has allowed a huge change of emphasis from quality of care to quality of life: from a medical model in which things are done to and for a resident to a model where a resident's choices and independence are the center of all activity.—*Bob Ogden, Administrator, Providence Mount St. Vincent, Seattle, WA.*

For one Kentucky nursing home resident, these provisions made a real difference.

> For 10 years, she worked in the housekeeping department of a Kentucky nursing home. Then she was diagnosed with a rare disorder of the central nervous system and at the age of 55 became a resident of one. Because Huntingdon's disease makes even slight changes to her daily pattern unbearable, adjusting to the nursing facility proved difficult. But the Nursing Home Reform Act's mandated assessment and family-participation requirements enabled her, along with her husband and three daughters, to work with the facility to ease the transition. She is now included in the decision-making and receives advance notice, in writing, of any changes in her daily routine. Disturbed by the noise and confusion in the facility's cafeteria, she eats in a small personal dining room, where it is calm and quiet. And, she sits in the same comfortable chair in the same familiar place each afternoon. The woman's youngest daughter said her family wouldn't have had a leg to stand on without the Nursing Home Reform Act supporting their right to secure individualized care for their mother. "I would not feel right if we just left Mom in an institution for someone else to take care of all the decisions," she said.

And, in the words of a long-time Washington, D.C., nursing home resident, the Nursing Home Reform Act

> ...was the beginning in restoring autonomy to those who thought they had lost it through physical dysfunction.—*G. Janet Tulloch, The Washington Home, Washington, DC*

The Nursing Home Reform Act affords residents the right to be free from chemical and physical restraints, a protection that has brought far-reaching changes, according to this nursing home medical director:

> Where the Nursing Home Reform Act has been most effective is in physical restraint reduction and significantly reducing the use of psychoactive drugs. Without the Act, it would have taken us longer to have these changes implemented and to have them as widely accepted. The Act allowed us to dis-

seminate the medical knowledge with the impact of the law behind us.—
Monte J. Levinson, M.D., President, American Medical Directors Association

America has become an increasingly mobile society, with families often separated by vast distances. Therefore, the national quality standards encased in the Nursing Home Reform Act are desperately needed to guarantee decent care and appropriate services no matter where a resident lives, and regardless of whether they are fortunate to have a loved one looking out for them. About half of all nursing home residents do not.

III. THE HIGH COST OF POOR CARE

In an era where accountability for public dollars is imperative, I am pleased to report that outcome data on the Nursing Home Reform Act support the long-held consumer view that providing quality care is cost effective, while allowing poor care to continue causes unnecessary suffering and avoidable costs.

According to a review of published literature, nursing home use of antipsychotic drugs—tranquilizers and other mind-altering chemicals—has declined about 30 percent since implementation of the Nursing Home Reform Act. The decline in the percentage of residents who are physically restrained has been even greater. Unpublished data from the U.S. Health Care Financing Administration shows use of vest restraints, leg ties and other immobilizing devices has dropped from a high of 38 percent before the Reform Act to a low of 21 percent in 1994. Widespread variability across states continues, with both Vermont and Iowa achieving rates below 8 percent. Though this disparity is regrettable, it does demonstrate the strong potential for further improvements in restraint reduction.

Meanwhile, published studies support the cost effectiveness of restraint-free care. The outcome of restraint-free nursing home care include residents who are more alert and independent, and less prone to drug-induced falls and debilitating skin ulcers and contractures that often require residents to undergo costly hospitalization.

It is not surprising that additional published studies show restraint-free care results in lower costs for nursing home care. A 1993 study published in the *American Journal of Public Health* found that residents who are physically restrained require more nursing care than their unrestrained counterparts, and thus are more costly to care for. Similarly, a 1993 study on reducing psychoactive drug use among nursing home residents in Georgia found stunning savings in drug expenditures. The study involved 9,500 nursing home residents, 85 percent of whom were Medicaid recipients.

Reducing these residents' psychoactive drug use generated monthly savings of $76,000. Beyond that, unpublished data indicate that limiting drug use protected residents against the costly consequences of inappropriate psychotropic drug use. As a result, it is possible to estimate that $90,000 a month was saved in incontinence care and $60,000 a month in food supplements and assistance with eating. In addition the study found that residents suffered 80 percent fewer falls. To put it another way, 60 residents were spared a fall, conceivably saving $250,000 a month in hospital costs for treatment of concussions, hip fractures and other broken bones.

More recently, preliminary results from another study support existing evidence that implementation of the Nursing Home Reform Act has brought measurable advancements. The study, to be published in a series of articles in 1996, used pre- and post-Nursing Home Reform Act data to evaluate the impact of the Resident Assessment Instrument. A key component of the Act, the Resident Assessment Instrument helps facilities determine each resident's strengths and weaknesses. The study involved 4,000 residents in 26 nursing homes in 10 states.

Major findings from this preliminary research include: a 25-percent reduction in hospital use; improved independence and stability among residents, even though the nursing home population in the years following implementation of the Nursing Home Reform Act suffer greater physical and cognitive impairment; decreased use of physical restraints; and decreased use of urinary catheters

The Nursing Home Reform Act promotes quality, cost-effective care

The provisions of the Nursing Home Reform Act not only protect nursing home residents, but also save state and federal dollars. Explosively expensive care is required to redress the effects of poor care in nursing facilities. Denying residents adequate nourishment, bathing, exercise, and assistance with eating and toileting leads to devastating outcomes for residents and additional expenses for government. The quality-of-care provisions in the Nursing Home Reform Act are designed to prevent these poor, costly outcomes.

While there are certainly costs associated with providing the kind of individualized care and services that prevent poor outcomes, clearly the cost of treating the

consequences of poor care are still greater. And, no statistician can ever attach a price to the pain of a gaping bedsore, or the avoidable loss of the ability to walk or go to the bathroom independently.

According to cost estimates for certain conditions from the literature, and pre-Nursing Home Reform Act resident-disability data from the Health Care Financing Administration:

- In 1990, the total health bill for incontinence in nursing homes was $3.26 billion. About half of all nursing home residents (795,000) were incontinent. At $6 per day, per incontinent resident, the costs for direct care totalled $1.5 billion. The consequences of incontinence—skin irritation, decubitus ulcers, urinary tract infections, additional hospitalizations—contribute to the estimated bill of $3.26 billion annually. Much of this is preventable when nursing homes carry out the quality-of-care provisions in the Nursing Home Reform Act.
- Skin breakdown is not normal for frail older people. Skin breakdown and resultant pressure ulcers occur most often when basic needs such as food, fluid, cleanliness and mobility are not provided. Pressure ulcers are preventable, yet 20 percent of nursing home residents developed pressure ulcers. It costs from $4,000 to $40,000 per resident to treat these ulcers, depending on the severity. The total annual cost of treating pressure ulcers ranged from $1.2 and $12 billion.
- Before passage of the Nursing Home Reform Act more than 35 percent of residents were physically restrained, and about the same number were given large, inappropriate doses of tranquilizers and other chemical restraints. Studies show that both types of restraints cause falls, many leading to hip fractures. In 1985, 98,291 nursing home residents suffered hip fractures, indicating that $2.6 billion was spent on avoidable hospital care.

Provisions in the Nursing Home Reform Act have helped to avoid these costly poor outcomes. In many places, however, these uniform quality standards are just beginning to take hold. To date, we have only scratched the surface of the improvements in quality of care and life and resultant savings possible under the Nursing Home Reform Act. Indeed, a recent independent investigation by *Consumer Reports* magazine found nursing home care in America ranges from "inadequate" to "scandalous" in part due to "erratic" enforcement of standards.

The recent implementation on July 1 of a new long-awaited federal enforcement system holds out the promise for continued strides on behalf of residents and reduced government spending. Abandoning the Nursing Home Reform Act in midstream will mean the collapse of critical progress in quality, cost-effective care.

A block-grant system will promote cost-shifting

Consumers are concerned that if Medicaid is converted into block grants, states will be inclined to use their newly granted flexibility to forgo the uniform standards in the Nursing Home Reform Act. As a result, the quality of nursing home care will suffer, and the federal government will be faced with financing the resultant Medicare-covered hospital costs for nursing home residents. Any discussion of transforming Medicaid must therefore explore ways not only to eliminate incentives for cost-shifting between the two programs, but also coordinate them toward achieving a more cost-effective, streamlined approach to care.

Like other advocates for long-term care residents, we are encouraged by the PACE Provider Act of 1995, sponsored by the Senate Majority Leader. Sen. Dole's proposed measure would pave the way for increased replications of the On Lok Pace program, a capitated joint Medicaid/Medicare model that in its limited application already has generated at least a 5 percent savings, while improving access to a range of long-term care services. Minnesota recently received a waiver to implement a pilot joint Medicare/Medicaid program serving elderly people nationwide.

Although managed care systems increasingly are providing health services to many Americans, older people with chronic illness have not been covered by these plans. Combining Medicare and Medicaid services under a single managed-care plan presents one avenue for exploration. However, it is important to bear in mind that managed care companies have virtually no experience with long-term care quality issues. Congress should thus proceed with caution in expanding managed care as a means to control health-care spending—remembering that, as the Nursing Home Reform Act has shown, quality care is cost effective.

The Nursing Home Reform Act is cost-effective and must be preserved

Mr. Chairman and members of the committee, we recognize the urgency of controlling the federal deficit. However, any budgetary plan that puts already vulnerable people at further risk is unacceptable. People in nursing homes depend on Medicaid as their sole means of access to quality, affordable services. They should not

have to pay the price for spending growth caps or restructuring schemes that jeopardize the integrity of this vital program.

Congress, and members of this Committee in particular, have acted responsibly in the past, recognizing and responding effectively to the needs of vulnerable nursing home residents. Current circumstances compel similar thoughtful and far-sighted initiatives. To be sure, we all must take this opportunity to review the nation's long-term care financing system, harnessing the creativity and commitment of everyone concerned about the well-being of America's elderly.

NCCNHR commends the Committee for holding this series of hearings on the Medicaid program. We look forward to working with you during the coming weeks and months to reduce costs and preserve national quality standards for nursing home residents.

Mr. BILIRAKIS. Thank you very much.

Mr. Eisenberg.

STATEMENT OF ALBERT EISENBERG

Mr. EISENBERG. Mr. Chairman, members of the subcommittee, I am Albert Eisenberg, Chairman of the Arlington, Virginia, County Board. I appreciate the opportunity to be here to represent the National Association of Counties and I very much appreciate your indulging my schedule.

NACO opposes the block granting of Medicaid. We think there is a significant potential for large cost shifts to county governments, particularly in those 30 States where counties are legally responsible for the care of the uninsured.

We have always viewed the Medicaid program as an intergovernmental partnership between the Federal, State and in about 20 States, county governments where they are partly responsible for the non-Federal match. The partnership has assured a basic level of services to persons who really have no other place to turn, regardless of the State in which they reside.

Capping the Federal contribution is going to leave the States and localities picking up 100 percent of the costs above the cap. The promised flexibility to the States, frankly, puts us in a straightjacket. It is going to force reductions in services or higher taxes, certainly in the context of numerous other budget cuts that are coming down the pike. We can shift no costs except to our citizens and your constituents.

We do, however, believe the change is warranted. Health costs have got to be controlled; we experience them too. Significant increases in our budgets for health and hospitals and those expenditures, I understand now, consume the largest percentage of an average county's budget and the annual percentage increases are also the largest.

We support a number of things. Increased use of managed care with proper consumer safeguards and standards. We support further targeting a disproportionate share program to hospitals and other facilities serving large numbers of the uninsured. We think you ought to pay attention to programs like the Federal Congregate Housing Services Program which helps the frail elderly stay out of institutions that they don't need and at home where they belong. We support increased flexibility in the waiver process for States and counties designing a program that responds to the needs of their populations.

It is reasonable for the Federal Government to set standards and then give States and localities the flexibility to meet them. The

savings estimates of the Congressional Budget Office, the Kaiser Commission on the future of Medicaid and others, just do not seem to show nearly enough savings from the policy positions that I have outlined. Based on our analysis of those numbers, the bulk of those savings are going to have to come from State and local cuts.

Frankly, we just can't see that almost as much as $100 billion in savings shortfalls can be found in just efficiencies. The States are going to pass us the buck and not the dollar.

Over the last few years, the majority of counties have increased their property tax and other revenues to make up for decreased Federal and State funds. They have also cut services and staff. Many are reaching or are at their State-imposed caps on raising revenues through the property tax. This leaves them very few alternatives.

My county, which is a full service county, we do everything, over the last 5 years, we found $100 million in savings in efficiencies in our budget, yet we have had to raise taxes, real estate taxes, four times.

Ultimately, this is not just about money. It is about how government will treat people, especially people who have little. We fear that the result is going to be the poor and sick people will simply get sicker and it will cost us at the local level even more to take care of them as they access hospital care that they really don't need and should have been able to avoid.

Mr. Chairman, your home district of Pinellas County shares NACO concerns and your supervisors would have been here except they had a county board meeting today and I didn't. Their problem with the cap may be exacerbated because of their elderly population which is 26 percent of that county's residents.

The nursing home population ranks among the top three counties in Florida and we have additional information on this in our statement.

As you redesign Medicaid, NACO also urges you to include provisions requiring States to plan a new program with counties. We know things because we are close to the action. What we ask is that you pay particular attention, I guess, to something that is really rather basic because we are talking about a medical program. In medicine, the first law is to do no harm and, in law, we would expect that to prevail as well.

We thank you very much for the opportunity to be here today and we are certainly prepared to answer any questions you may have.

[The prepared statement of Albert Eisenberg follows:]

PREPARED STATEMENT OF ALBERT EISENBERG, SUPERVISOR, ARLINGTON COUNTY, VIRGINIA ON BEHALF OF THE NATIONAL ASSOCIATION OF COUNTIES

Mr. Chairman, members of the subcommittee, I am Al Eisenberg, supervisor in Arlington County, Virginia. I am testifying on behalf of the National Association of Counties[1] (NACO). Thank you for inviting us.

[1] The National Association of Counties is the only national organization representing county government in the United States. Through its membership, urban, suburban and rural counties join together to build effective, responsive county government. The goals of the organization are to: improve county government; serve as the national spokesman for county government, serve as a liaison between the nation's counties and other levels of government; achieve public understanding of the role of counties in the federal system.

Our message is a simple one. NACO opposes the deep reductions in the rate of growth in Medicaid. We believe that the savings in the budget resolution are so large that there will be federal cost shifts to states and counties.

NACO has always supported Medicaid as an individual entitlement. We have long viewed it as an intergovernmental partnership between the federal, state and, in some cases, county governments. This position was reaffirmed in a bipartisan fashion at our annual conference last week.

Our position has philosophical and pragmatic underpinnings. While we support block grants of discretionary programs, NACO opposes block grants for entitlements such as Medicaid. We believe that the federal government should assure a minimum level of health benefits to nationally-defined groups of eligible persons, regardless of the state in which they reside. On the practical side, in about 30 states, counties are legally responsible for the care of the uninsured. In about 20 states, counties share in a portion of the non-federal match for Medicaid.

Mr. Chairman, your home district of Pinellas County, Florida shares NACO's concern about cost shifting. Both County Board Chairman Steve Seibert and Commissioner Sallie Parks were prepared to testify today, but they had to attend their county board meeting. Pinellas is particularly concerned about the effect a formula cap will have on financing care for Florida's fast growing population. As you know, twenty-six percent of the county's population is 65 years of age or older. Their nursing home population is one of the top three in the state. They have not seen the private sector move to managed care for this costly population. The county currently has over 75,000 Medicaid recipients and another 82,000 uninsured.

With no track record of HMO-type nursing homes and the county's responsibility for the uninsured, Pinellas urges you to continue to keep in mind the local constituent and policy outcomes of this budget initiative. I have also attached a short statement from the Florida Association of Counties.

Under a block grant, the costs above the federal cap will be borne 100 percent by the state or county. Counties, especially those that are responsible for the care of the uninsured, will have to choose between raising taxes or cutting other services to respond to the shortfall.

While we oppose the deep reductions in Medicaid, we do not support maintaining the status quo. Clearly, savings can be achieved in the program. Many counties have increased the use of managed care for children and their families, which must be accompanied by standards and consumer safeguards. NACO also supports the further targeting of the Disproportionate Share Program (DSP) to facilities serving large Medicaid and uninsured populations. we also support increased state and local flexibility in operating the program.

County officials are politically accountable to the same taxpayer as are governors and Congress. They have to meet their budgets and comply with state and federal requirements. They too have seen a dramatic increase in health and hospital spending, which now represents the largest expenditure in an average county and is also the fastest growing part of their budgets. From FY 1991 to FY 1994 health spending increased 32 percent, according to a 1994 NACO survey of small and medium sized counties.

Many county officials have raised taxes a number of times to meet their constituent's needs and to respond to cuts in federal and state aid. According to our fiscal survey, 45 percent of medium to small counties reported increasing their property tax. Over one-third of the large urban counties did the same. Over 60 percent reported raising fines, fees or other charges. Over one-third were making significant cuts to their budgets and laying off employees.

While making the tough decisions to raise revenues, many counties are reaching or at their limit on raising the property tax—the main source of local revenue. According to the advisory commission on intergovernmental relations, forty-two states have imposed property tax limits and 27 limit the amount of revenues that can be raised from this source.

Raising revenues and cutting services are not the only ways counties are responding. In health, many counties are already aggressively pursuing managed care for women and children. We are also transforming a number of our public facilities to operate more efficiently in today's changing budgetary and health delivery climate. County officials are spending their constituent's tax dollars effectively while federal and state funding is being frozen or decreased.

The proposed reductions in Medicaid, combined with county government responsibilities for the uninsured and our political and statutory limits on raising property taxes, place counties and their constituents at great risk.

Counties are at great risk because the policy assumptions for saving Medicaid dollars fall far short of what is needed. The preliminary savings estimates by the Congressional Budget Office, the Kaiser Commission on the Future of Medicaid and oth-

ers do not add up to $182 billion assumed in the budget resolution. The combination of increased managed care, DSH targeting, and repealing the Boren amendment which requires states to follow reimbursement directives do not get us close to that figure.

Let me explain why NACO's Democratic and Republican county officials are so concerned about the numbers.

Most of the estimates assume that all the policy changes would take place on October 1st—60 days from today. There is a huge budget shortfall over seven years even if all children and non-disabled adults were placed into managed care by that time ($28 billion in savings over seven years), DSH was cut by nearly half (saving another $28 billion) and Boren was repealed ($4.2 billion over 7 years, according to CBO). These savings assumptions total $60 billion.

If we threw in a cushion of $20 billion, there is still a shortage of over $100 billion. That leaves administrative efficiencies to pick up the rest. Counties will do their share, and support increased state and local flexibility, but we do not believe that there is $100 billion of administrative fat.

In addition to our support for managed care, DSH targeting and increased flexibility, we are open to the concept of a capped entitlement to individuals. The guarantee of coverage would be maintained, and counties would have more budgetary predictability to respond to economic downturns or the unique demographics of their Medicaid population.

In the redesign of Medicaid, we also urge the committee to include a provision requiring states to plan their new systems with those counties who are involved in the funding or delivery of Medicaid services. While some may view this as a mandate on the states, counties view state rules and regulations with the same concern as they do federal requirements. Involvement in the planning will also give states some additional expertise from a significant provider and intergovernmental partner in Medicaid.

We also urge the committee to give states and counties ample time to respond legislatively and administratively to the changes. County governments are at the intergovernmental end of the budgetary and service line in health. These proposed changes will shift enormous costs to us while we continue to meet the health needs of the uninsured.

Thank you again for this opportunity to testify. I will be happy to respond to any questions you may have.

Mr. BILIRAKIS. Thank you very much, Mr. Eisenberg, and particularly all of you for being patient with us.

Mr. Waxman, to inquire.

Mr. WAXMAN. Thank you, Mr. Chairman. I want to thank the members of this panel. I think you have given us excellent testimony.

So as we look at the possibility of a block grant replacing the entitlement for Medicaid, we look as well at repealing a lot of the laws under which Medicaid has operated.

I guess the first question I would ask of Ms. Braun from AARP or maybe Ms. Waxman, or Mr. McConnell, under current law there is a protection for the spouse if someone is in the nursing home. We wrote in there that we will protect a minimum of $1,230 in monthly income and $14,964 in resources for the maintenance of the community spouse, that is the spouse of the person who is in the nursing home under Medicaid. And we also say that the nursing home can't turn around and balance the bill for more money for these people who are on Medicaid.

But if we adopt a block grant and we want to give the States flexibility, there is no guarantee anymore that we will have those protections. I would like to know how you think the States might respond? Will they maintain the current protections for community spouses or will they reduce or eliminate them altogether? Will the States freeze or reduce payments to nursing homes and allow the homes to charge residents and their community spouses for the difference between their charges and what the State actually pays?

And if a State chooses to maintain the current protections for community spouses, whose coverage will they terminate to adjust for the loss of Federal matching funds?

Whichever of you want to respond.

Mr. McCONNELL. I think we are beginning to see some of what your questions suggest already in States. In Wisconsin, for example, the Governor proposed reducing the asset protections under spousal impoverishment from the maximum to the minimum and it was only through advocacy that they were able to hang on to some spousal impoverishment protection. So if the Federal requirement under Medicaid is eliminated, I think we are going to see States finding ways to somehow get around that issue.

In terms of payment to nursing homes, once again I think what we are already seeing is States are turning to private pay patients and hitting them harder to help make up for shortfalls and if there is no requirement preventing them from going after Medicaid recipients to balance bills, they are going to do that. So I think we are already seeing the future.

Mr. WAXMAN. Ms. Waxman?

Ms. WAXMAN. I think the reason those spousal impoverishment protections were put into the Medicaid law in the first place was because we were hearing from many, many couples who were afraid about what would happen to the spouse at home. Let's take Mrs. Faris, who we had hoped would be here today. If she had to give up everything that she has to put her husband in the nursing home, and in fact she had to, he would wander, he was becoming abusive, I mean, the doctors said she couldn't keep him at home anymore. So how would she survive at home if not for those protections that we already have? And she has spoken to that about her fear and her thankfulness for the fact that she knew that without the Federal protection, that her State did not in the past provide that for people such as herself and she assumed would not in the future.

Mr. WAXMAN. Let me interrupt you before Ms. Braun responds. A State wouldn't want to do that. They care as much about the community spouse as the Federal Government. We have heard over and over again the argument that if we let the States run the program and they had flexibility, they are not going to abandon the community spouse, they are not going to cut back on nursing home standards, they are not going to reimburse the nursing homes at inadequate rates. They are not going to do all these terrible things.

But doesn't something have to give?

Ms. WAXMAN. That is true. One answer is, of course, they did do that until the Federal law changed. So it really took Federal law——

Mr. WAXMAN. You mean the States that were close, right there, living with the people they served did those terrible things?

Ms. WAXMAN. Unfortunately, that is true, Congressman. And so it did take your committee to make the changes to protect those spouses at home.

And how to answer the question, what if indeed these protections remain and what would the States do? Well, we fear for that and I don't know what each and every State would do. But we have heard many times this morning already, undoubtedly more and

more people will lose coverage, the safety valve that we have and some providers who are now able to care for this population as well as the uninsured will suffer greatly and obviously we will have a very deteriorating situation.

Mr. WAXMAN. Ms. Braun?

Ms. BRAUN. I certainly would agree with what has been said before. I think it brings up two problems actually because the States are put in the position if there is a cap on the money, do they cut eligibility, do they cut people out of the program or do they cut something else like spousal impoverishment. And I remember all too well the days before that law was in place and the great suffering that we saw from spouses when a spouse went into a nursing home. So I would feel very strongly on that.

Mr. WAXMAN. Mr. Chairman, just to complete this thought.

We have nursing home standards at the Federal level. Before that, we had terrible abuses that we heard about. I just think we have to acknowledge that if we give the States ultimate flexibility they may not be able to meet those nursing home standards. So these are some of the things that bother a lot of us because the States are going to be under so much pressure.

Mr. EISENBERG. Mr. Chairman, may I respond very quickly?

Mr. BILIRAKIS. Very quickly, if you would, please.

Mr. EISENBERG. This past year, the State of Virginia attempted to cut from its program indigent children who were 12 to 18 years old. The General Assembly stopped them from doing that, but that was the State proposal. That burden would have fallen on Arlington County and all the other governments in Virginia to pick up the slack.

Mr. BILIRAKIS. Part of the State is the General Assembly, though, or vice versa, so——

Mr. EISENBERG. The thing is it was proposed.

Mr. BILIRAKIS. The gentleman's time has expired.

Dr. Ganske.

Mr. GANSKE. Dr. Willging, why is employment in nursing homes so dangerous or do you agree with that assertion?

Mr. WILLGING. I disagree with that assertion. I read the report from which the assertion comes done by the Service Employees International Union.

It is clear that because of the amount of lifting that is done by nurses' aides in nursing facilities and the amount of stress that is involved that it is not a job without risks. To suggest that it is the most dangerous occupation around, even more so than coal mines, is based on a very flawed study which was more a recruitment brochure for SEIU than it was an honest attempt to look at ergonomics issues.

There was no attempt to distinguish between severe injuries and nonsevere injuries, no attempt to distinguish between minor back pain as opposed to really debilitating kinds of injuries.

There is also no question, however, that because we do have lifting issues within nursing facilities, we need to continue to examine how best we can accommodate those kind of problems and we are doing that, even to the extent of testing new equipment, to the extent of looking at different techniques. So we recognize there is a

problem. We certainly do not agree that it is as big a problem as has been suggested by SEIU.

Mr. GANSKE. It would seem to me that there would not be all that much difference between the type of lifting requirements in regular hospitals and in nursing homes.

Mr. WILLGING. As I say, not as serious a problem as some would allege. Furthermore, what we have tried to suggest is that we are nursing homes, we are not meat packing plants.

To simply suggest that you can simply use a mechanical hoist which has been suggested, every time you need to lift or transfer a resident at a facility from one location to another, violates the very concept of what it is we are trying to accomplish and we simply outright refuse to accept that as the best solution.

Furthermore, I rather believe that the market often provides more inducements than do more regulations. We pay premiums for something called workers compensation and the more injuries, the more problems there are in a facility, the higher those premiums are. We have an inducement to do whatever is possible within our existing fiscal environment to keep those injuries down to the most reasonable level possible.

Mr. GANSKE. We have had some comments on the 1987 Nursing Home Reform Act. Would you care to make a few comments on that bill?

Mr. WILLGING. I believe that the American Health Care Association supported a good part of what this committee passed and what was ultimately passed by the Congress. We have had some problems with parts of that legislation but, as this committee itself recognized, much in the Nursing Home Reform Act was simply a reflection of what was already going on in many good nursing facilities across the country.

One thing we do have to recognize, however. That some of the greatest advances that were a result of that legislation were because we were given the resources to provide additional staffing. I mean I will never for a moment defend a situation as we had in the State of Oklahoma where, prior to the Nursing Home Reform Act of 1987, you had in that State a requirement for only one LPN on one shift per day. In other words, we had 16 hours a day where there were no nurses at all in the nursing facilities. The reason was because of the fact that there was not the reimbursement provided by the State Medicaid program to allow for the hiring of additional and qualified nurses.

The Nursing Home Reform provision did in fact provide for that and it provided for the dollars it would pay for it. My concern and to some extent it does reflect the question that was raised by Congressman Waxman, is how do you then accommodate the cuts in long-term care where the growth is capped at 4 percent yet most of the growth is a result of demographics and increased levels of sickness or acuity in facilities.

Seventy percent of the costs in a nursing facility are labor. The only way to accommodate those kinds of cuts would be to reduce the labor, to reduce nurses, to go backwards in terms of what we are trying to accomplish.

The nursing home today, Mr. Congressman, is not even close to the nursing home of 25 or 30 years ago. We are, to some consider-

able extent, taking the place of hospitals with respect to many diagnoses. We need more, not less, personnel; we need more, not less, technology in those facilities. So it is a dilemma.

On the one hand, we recognize and accept the fact that we need to transform this Medicaid program. We can't continue to see the public sector alone with primary responsibility for funding. On the other hand, we can't simply ignore the problem and the reasons for the growth in that program. Which is why we are suggesting, begin to emphasize the private sector along with the public sector. Emphasize long-term care insurance, emphasize asset transfer prohibitions.

Mr. GANSKE. You just brought up my next question. I think that a fair portion of the public is bothered by somebody who does have substantial assets who is ready to go into the nursing home, transferring those assets to other family members.

Specifically, what would you propose to address that issue?

Mr. WILLGING. I once again reference the Heritage Foundation report which just within the last few months suggested there might be up to $5 billion per year.

I guess what I would suggest in maintaining a Federal role is to at a minimum look to actual implementation of legislation that has already passed the Congress in terms of asset transfer. Whereas the Governors are looking for an actual repeal of some of that legislation such as the ability to attach liens on estates.

No one should touch anyone's estate once the individual or as long as the individual is in the facility or a dependent relative or spouse is living in that home. But why, after the government has paid $30-some-thousand per year should that estate pass on to the children who did not contribute to the care of mom or dad in the facility. I mean, that's absurd and we would suggest we begin to tack into those countless billions of dollars and make sure that the government is reimbursed if it has paid out on behalf and as long as we do not inconvenience the person who is living, the dependent individual living in that house.

Mr. GANSKE. I see that my time is up. Thank you.

Ms. WCISLO. Could I do a quick response?

Mr. BILIRAKIS. Yes, quick.

Ms. WCISLO. In reference to the injuries and the rate of injury in the nursing home industry, if there is any skewing of the statistics, they come from the Bureau of Labor Statistics collected by this government. There has been a 50 percent increase as the patient acuity has increased, as pressures on staffing have gone down.

This industry has led to more occupational industries than any other industry in the United States today.

Mr. BILIRAKIS. Thank you, Dr. Ganske.

The QMB program that 2 or 3 of you mentioned, I am sure you are all concerned about it, we are also very concerned about it. We have had an awful lot of hearings here, we have heard from so many States. But we are very concerned about it too and our feeling is that one way or another we are going to get that covered. But if I have anything to do with it, and really all the people that I have talked with in meetings we have had and that sort of thing, staff and otherwise, there is this very strong feeling that we would

retain it in some fashion. It would be covered one way or another, by Medicaid dollars or by the States.

Ms. WAXMAN. Well, that's great. Obviously, we welcome working with you on that. But I will say that that will not actually lessen our objection to a block grant because we are worried about the other protections as well.

Mr. BILIRAKIS. I appreciate that. But I just wanted to set your concern at ease there.

I guess you have all emphasized the long-term care, care for the elderly. Mr. McConnell mentioned my interest in Alzheimer's, and I appreciate your knowing that, sir. And it is quite an interest, long-time interest, I might add.

Now, I am losing my voice and I am not sure why but we are trying to address these areas. In the process, and I can't go too far, mainly because there isn't too far to go at this point but in the process of developing whatever concept we come up with here, the care for the elderly, the long-term care, and you can imagine, Ms. Braun, considering the district that I come from, that certainly that would be paramount in my thinking. So we are trying to address that as well as we possibly can.

Again, Mr. Willging mentioned some of these other poor things that have taken place in the past. The asset transfer that you mentioned and your comments, your more recent comments about why should the estate go down to the children when the children haven't even been helpful and that sort of thing, I've seen a lot of that because I practiced law for a little while in that area of West Pasco County and I have seen an awful lot of that takes place too. Frankly, it was just very distasteful for me.

Mr. Eisenberg, would you propose that if a block grant program were to take place, would you feel better about it at all if it were done on a county level?

Mr. EISENBERG. I am sorry, I didn't hear the last part of your question.

Mr. BILIRAKIS. If a block grant concept were to take place, would you feel better about it if it were done on a county level as against a State level?

Mr. EISENBERG. You mean if there were some kind of pass-through or if it were shared? If we have to start with the concept of a block grant then sharing, certainly, with the larger metropolitan areas, certainly with communities that have capacity would be a very important concept.

We do certainly ask that if block grants are to come to pass, we have a hand in shaping how the State will use them and if, in fact, there is a way that you can fairly devise a formula that meets the great questions of fairness and population needs and what have you. Certainly, just like there are all kinds of programs throughout the Federal Government that does recognize a sharing between the States and the localities, that would be a principle that we could work with.

Mr. BILIRAKIS. In spite of some of the comments that were made here about past State abuses and that sort of thing, the Federal programs haven't worked perfectly either. I think we would all agree there. But you don't have a level of confidence at all in your

State authorities that they would have as much sense of caring and that sort of thing for their people?

Mr. EISENBERG. Mr. Chairman, before there was a Federal Government, little villages and towns had great concerns about the colony's capitals. I mean, the tension between the State or provincial or colonial body in the localities has been with us throughout our history and that tension is going to continue. The question is, today, how localities will relate to their States in this era of changing intergovernmental relations.

What we are saying very clearly here is the extent to which you all at the Federal level feel that you must devolve things to the State level, those of us who are at the very end of the food chain, who are downstream where everybody lives, have got to have a say in how those States are going to work with their programs because ultimately those of us at the end of the line are directly responsible to the citizens that elect us, to the people that we see on the street corner and work with on a daily basis.

Mr. BILIRAKIS. But aren't you closer to those people in terms of direct responsibility and direct influence, if you will, than you are to the Federal Government? Not you, because you are Arlington but, in general, the counties around the country.

Mr. EISENBERG. You mean with their States?

Mr. BILIRAKIS. Sure.

Mr. EISENBERG. Oh, it depends upon the State. Some of the relationships with localities are terrible. In other cases, they are quite good but the principle still holds. Government has got to be a partnership, intergovernmentally and with the people that we all serve and in that context we all have to have a seat at the table.

Our problem with the block grant concept as we understand it being proposed right now is half that we are going to get stuck with higher costs because you are going to cap it. That is half of the equation. The other half of the equation is that unless we have a guaranteed seat at the table to work with our States, then the States will have nothing there that pushes them properly so to share as they ought to be sharing.

Mr. BILIRAKIS. Well, all right, I can't disagree with that statement, but are you suggesting that the Federal Government can ensure that you have a seat at the table? Why can't you with your own State authorities—after all, you elect them, you are closer to them, you probably know them a heck of a lot more than you may know your Federal representative—why can't you use the influence with them that you would attempt to use with us?

Mr. EISENBERG. I might know 3 of them or 4 of them. I might know the ones that represent my community or even the ones within my region. But I have got no control over what happens with respect to the people at the other end of the State, people that have very little connection with our urban community and have no concept of the kinds of problems that we have.

I can assure you, in a State like Virginia or even a State like Florida, there is a great difference between the panhandle of your State and Miami as there is from Big Stone Gap to Arlington County. And there are great differences in how people understand things and I can't influence all of them.

Mr. BILIRAKIS. There are great big differences between Oregon and Florida in many respects. So when you are talking about differences, you are right, there are a lot of differences.

Well, I don't know. I just can't quite understand why we—there is a feeling that there isn't going to be as much influence with local legislators who may be neighbors, who represent a much smaller geographical area and a much smaller population and whatnot as against a Federal legislator who represents 600,000 people and a much wider area. I guess I can't get that clear.

I can tell you this, over the years we have all spent time with municipalities and talked to their officials, their mayors, their city commissioners. The biggest complaints that I have gotten have been with the Federal Government with the Federal regulations, with the Federal strings, the Federal bureaucracies from the municipalities and even the local counties, much more so.

Now, maybe I wouldn't get them regarding the State because I am not a State legislator, but that's been my experience.

Well, all right. I think——

Mr. EISENBERG. Mr. Chairman, you all have to set a level, you all have to set a basic—with all due respect, the Federal Government, I believe, has a responsibility to set a basic minimum level of how—minimal level in terms of the rules of the game and one of the rules of the game is that as you move responsibility down to the State level that the door has to be open for all of us to work together.

Don't tell people exactly how that will be done but please make sure that, in fact, the table is open, the door is open and we have State localities and citizens and groups like those at this table having an opportunity to impact the process under which we all will live and that's all we ask.

Mr. BILIRAKIS. Do you have suggested language to that end?

Mr. EISENBERG. We will have some forthwith.

Mr. BILIRAKIS. Make it very forthwith, would you, please, Albert?

Mr. EISENBERG. Yes, sir. I appreciate your indulgence.

Mr. BILIRAKIS. Well, this has been a fine panel and, if you do it very quickly, sir.

No, we are not going through a second round, but if you would like some time?

Mr. WAXMAN. I would like some time.

Mr. BILIRAKIS. A couple minutes.

Mr. WAXMAN. First of all, let me say I am very pleased to hear that you are going to do something to protect the QMB program. I think that is important for low-income seniors. But I hope that if you are going to do that, we also do something to protect the community spouse whose family member is in the nursing home, because otherwise they may get wiped out.

As we look at the possibility of a block grant, we have to be concerned not just that we are giving them flexibility but that we are not writing in some minimal protections. Even Dr. Willging talked about getting more money from those people who are hiding assets in order to qualify for Medicaid.

I might point out that if we had a block grant, we are giving the States the flexibility not to enforce those laws. In fact, two States as I understand it, Michigan and Texas, are refusing to abide by

the existing Federal laws to go after assets that are being transferred in order to make people eligible. Maybe this is an area where we will want some uniformity so that we don't have people becoming impoverished in a pseudo way and then going off to a State where no one will ever check the transfer of assets.

I wanted to ask Mr. Eisenberg, one of the concerns that we hear if we have a block grant is that States are going to be reluctant to try to innovate or have generous programs for poor people for fear that they will be a magnet for people from other States. How would that apply to counties?

Would you worry that if your county were more generous for poor people that you might be a magnet for others? If not your county particularly, do you think that is a problem with other counties? Are we going to have a race to the bottom between counties within the State as we have a race to the bottom between States throughout this country?

Mr. EISENBERG. First of all, as Justice Brandeis said, localities are the laboratories of democracy. We are where the creativity occurs. Second, the extent to which we are creative at the local level in my county, Fairfax, Alexandria, Prince William, all of us are trying to do creative things and the fact is that people in today's society drift back and forth across borders for a variety of reasons, not just to get benefits but to get jobs, go to recreation and do all the kinds of things that people do in normal daily living.

We may get some overflow for one reason others may get for another reason and there is also an increasing, increasing interest today in regional sharing of responsibilities. I don't believe that because we happen to be creative in addressing the needs of our low-income people that we would necessarily be a magnet for those individuals.

Mr. WAXMAN. In conclusion, Mr. Chairman, let me just say to you I want to work with you as best we can to bridge differences that we have. If we are going to turn the Medicaid program, which is really the safety net for the poor the really poorest of the poor, over to the States, I want to make sure that we don't have people fall through the cracks. And just as you expressed concern for the QMB program, let's work together to be sure we have other protections for the elderly but also kids.

Because I worry, from this morning's panel, that the kids are going to lose out when there is greater political force to try to take care of the elderly and they have to make cuts. Maybe the elderly will be better taken care of and kids will be cut adrift. So let's set up some minimum standards, giving States a lot of flexibility but making sure there is no population group that is just lost in the whole shuffle.

Thank you, Mr. Chairman.

Mr. BILIRAKIS. I thank the gentleman.

This panel is excused. Thank you so very much for your immeasurable help.

Well, the last panel, Panel Number V, will consist of two panelists. A number of others have previously testified.

Mr. Larry S. Gage is President of the National Association of Public Hospitals and replacing Mr. Martin Goldsmith is Mr.

Charles DeBrunner, Executive Director of Urban Health Care Coalition of Pennsylvania. Mr. Gage and Mr. DeBrunner, right.

Okay, gentleman, your written testimony, of course, is a part of the record. I would appreciate it if you could hold your testimony as close to 5 minutes as possible and I will, again, thank you in advance for your patience sitting through these long proceedings, but somebody's got to be last and unfortunately today it was you.

Let's start off with Mr. Gage. Please proceed, sir.

STATEMENTS OF LARRY S. GAGE, PRESIDENT, NATIONAL ASSOCIATION OF PUBLIC HOSPITALS; AND CHARLES DeBRUNNER, DIRECTOR, FEDERAL AFFAIRS, URBAN HEALTH CARE COALITION OF PENNSYLVANIA

Mr. GAGE. Thank you very much, Mr. Chairman, and thank you for providing us with some more elbow room up here by accommodating some of the panelists earlier.

I am Larry Gage, President of the National Association of Public Hospitals. NAPH's members include over 100 of America's metropolitan area safety net hospitals which provide nearly 90 percent of their services to Medicare, Medicaid and low income, uninsured and underinsured patients. They also provide many preventive, primary and costly tertiary services to their entire communities and not just the poor and elderly. These services include maintaining a wide variety of round-the-clock standby care such as trauma units, burn centers, neonatal intensive care, poison control, emergency psychiatric services and crisis response units for both natural and manmade disasters.

With their overwhelming reliance on governmental funding sources, America's urban public hospitals are as concerned as members of this committee with rising health costs. In the process of controlling these costs, we recognize that it may be necessary for some public hospitals to merge, downsize or consolidate. Already, many safety net hospitals are moving ahead rapidly to become more efficient and effective providers of care. They are responding, for example, to the demand for increased managed care and are working closely with many States in developing these more innovative and flexible Medicaid programs.

But this transformation cannot take place over night or in the absence of a continued Federal role in health policy. The marketplace alone will not adequately protect the safety net infrastructure of our Nation's health system. My prepared testimony focuses on four general areas of concern which I will very briefly summarize.

First, since we have not testified for some time before this committee, we take this opportunity to bring you up to date on the situation of public hospitals in America's major metropolitan areas today. In particular, we have provided an overview of the challenges already being faced by these essential providers of care to Medicaid patients and the uninsured.

Recent events in Los Angeles County are only the tip of the iceberg but they may help to illustrate the growing crisis facing America's urban health safety net. Due in part to the ongoing economic problems facing California and in part to reductions in Medicaid spending already imposed by past State and Federal actions, the Los Angeles County Administrative Officer recommended several

weeks ago the closure of LA County USC Medical Center, one of the largest and busiest public hospitals in the country.

To put this crisis into perspective, LA/USC Medical Center provided over 66,000 inpatient admissions, nearly 14,000 live births and close to 700,000 outpatient and emergency room visits in 1993. Ninety-four percent of their admissions and 85 percent of their outpatient and emergency visits were for the uninsured and for Medicaid patients.

From any perspective, the closure of this institution would be a major disaster for the county's entire health system, not just the Medicaid program. This crisis, which has been acknowledged to be one by all of the hospitals in the Los Angeles area, has not yet been resolved and this is only one of a number of safety net systems around the country that could face similar action if reductions of the size and scope of those proposed in the budget are ultimately implemented.

Second, I would like to express NAPH's support for genuine reform of the Medicaid program. At the same time, NAPH members and other providers that care for disproportionate numbers of the poor and uninsured believe that no real reform will be possible if we also must implement over $450 billion in combined Medicare and Medicaid cuts that are mandated in the resolution. We do accept the fact that Americans want less government, fewer regulations and ultimately a balanced budget. However, we disagree that they want to meet these goals by decimating our Nation's health and social infrastructure and eliminating any semblance of a safety net for the poor and disenfranchised.

We have a number of concerns about some of the proposals that have been made to implement a capped but unfettered Medicaid block grant. These concerns and several recommendations for more moderate cuts and reforms are also described in my prepared testimony.

Third, NAPH recognizes that there are significant concerns about the uses of Medicaid disproportionate share hospital or DSH payments in recent years. We share those concerns and we want to work with the committee to do whatever is necessary to address them. At the same time, we must not lose sight of the original intent of this program, to assist providers that are truly serving large volumes of Medicaid and uninsured patients. This goal will be even more important in the future than it is today.

We would like very much to continue to work with the committee to ensure if necessary a more precise targeting of Medicaid DSH payments to high-volume providers of care to the poor.

And fourth and finally, I would like to offer a few observations about managed care. NAPH supports the concept of managed care generally. However, based on recent experiences in Tennessee, Florida, New York and other States, we are concerned about the ability of the managed care industry to meet the needs of the current rapidly growing population of Medicaid enrollees, let alone accommodate a significantly expanded Medicaid and Medicare population in the short term.

In conclusion, Mr. Chairman, without an adequate managed care infrastructure in place, hope for improvements in prevention, primary care and the health status of the poor and elderly, which are

all goals of managed care, simply will not occur leaving cost containment as the only achievable goal. Cost containment alone, of course, can be easily achieved in the short run by simply setting premiums at arbitrarily low levels. But this is going to prove to be an expensive way to contain costs in the long run. It could result in reduced access and choice for the poor and elderly, reduced support for essential community-wide services and ultimately a reduction in the good health of all Americans and not just the poor.

Thank you very much and I would be happy to answer any questions.

[The prepared statement of Larry S. Gage follows:]

PREPARED STATEMENT OF LARRY S. GAGE, PRESIDENT, NATIONAL ASSOCIATION OF PUBLIC HOSPITALS

I am Larry Gage, President of the National Association of Public Hospitals (NAPH). NAPH's members include over 100 of America's metropolitan area safety net hospitals. These 100 institutions (taken together) comprise America's most important health and hospital system. With combined revenues of over $17 billion, these hospitals provide nearly 90% of their services to Medicare, Medicaid and low income uninsured and underinsured patients. They also provide many preventive, primary and costly tertiary services to their entire communities, not just the poor and elderly. These services include maintaining a wide variety of round-the-clock standby care such as trauma units, burn centers, neonatal intensive care, poison control, emergency psychiatric services, and crisis response units for both natural and man-made disasters.

In just the last two years, NAPH members have been at the forefront of the response to community-wide crises that have included fires, floods, earthquakes, deadly new viruses, measles epidemics, environmental spills, air crashes, and urban riots. At the same time, their preventive and primary care services have been essential to meeting the day-to-day health needs of many millions of urban residents with restricted access to "mainstream" health services. In other words, these essential health systems—which rely on Medicaid, Medicare and direct state and local governmental subsidies for over three quarters of their operating revenues—already serve as a "national health system" by default in most of our nation's urban areas.

With their overwhelming reliance on governmental funding sources to carry out their essential mission, America's urban public hospitals are as concerned as members of this Committee with rising health costs. In the process of controlling these costs, we recognize that it may be necessary for some public hospitals to close, merge, downsize or consolidate. Already, many safety net hospitals are moving ahead rapidly to become more efficient and effective providers of care. They are responding, for example, to the demand for increased managed care and are working closely with many states in developing more innovative and flexible Medicaid programs.

At the same time, we ask for recognition and support for these essential providers in their ongoing struggle to meet the basic needs of their patients and communities: Recognition that at a time of national belt-tightening and unprecedented attention to America's health costs, it has never been more important to ensure that the underlying foundation of our health system is sound; and Support for protecting and strengthening the core programs and providers which make up that foundation.

My testimony today will focus on four general areas of concern with respect to the healthcare policy issues confronting you this year: First, I would like to bring you up to date on the situation of public hospitals in America's major metropolitan areas today, with an overview of the challenges already being faced by these essential providers in carrying out their safety net missions.

Second, I would like to express our support for genuine reform of the Medicaid program. At the same time, I would like to make clear that NAPH members, and other providers that care for a significantly disproportionate number of the poor and uninsured, believe that no real reform will be possible in the context of the $450 billion in combined Medicare and Medicaid cuts mandated by the Congressional budget resolution. While we accept the fact that Americans want less government, fewer regulations, more marketplace competition, and ultimately, a balanced federal budget, we disagree that they want to meet those goals by decimating our nation's health and social infrastructure and eliminating any semblance of a safety net for the poor and disenfranchised. In particular, NAPH has a number of concerns about

the proposals being developed to implement a Medicaid block grant to the States, which are described in this second section of my prepared testimony.

Third, NAPH recognizes that there have been significant concerns expressed regarding the uses of the Medicaid disproportionate share hospital (DSH) payments in recent years. We share those concerns and want to work with the Committee to do whatever is necessary to correct them. At the same time, we want to make clear that the original intent of this program—to assist providers that are truly serving large volumes of Medicaid and uninsured patients—will be even more important in the future than it is today, in light of the scope of the Medicare and Medicaid budget reductions being proposed. We believe this will be true whether or not the Medicaid program is block granted in an effort to achieve these reductions. We would like very much to continue to work with the Committee to ensure that there is ongoing support and strengthening of America's health safety net, including a more precise targeting of Medicaid DSH payments to high volume providers of care to the poor.

Fourth, and finally, I would like to offer a few observations and recommendations about managed care. NAPH supports the concept of managed care generally. However, based on recent experiences in Tennessee, Florida and other states, we are concerned about the ability of the managed care industry to meet the needs of even the current rapidly growing population of Medicaid enrollees, let alone accommodate a significantly expanded Medicaid and Medicare population in the short term. Without an adequate managed care infrastructure in place, hoped-for improvements in prevention, primary care and the health status of the poor and elderly simply cannot occur, leaving cost containment as the only achievable goal. Cost containment alone, of course, can be easily achieved by simply setting premiums arbitrarily at levels designed to achieve the desired savings. But this could prove to be a costly way to contain costs, which may result in reduced access and choice for the poor and elderly, reduced support for essential community-wide services such as trauma care, burn care and neonatal intensive care, and ultimately, a reduction in the good health of all Americans, not just the poor.

I will address each of these points in more detail in the remainder of my testimony.

I. The situation of urban public hospitals and other essential providers has never been more precarious than it is today, even before implementation of the planned budget reductions.

Recent events in Los Angeles County are only the tip of the iceberg, but they may help to illustrate the growing crisis facing America's urban health safety net. As the Committee may know, due in part to the ongoing economic problems facing California and in part to reductions in Medicaid spending already imposed by recent state and federal actions, the L.A. County Supervisors voted several weeks ago to close the Los Angeles County + USC Medical Center—one of the largest and busiest public hospitals in the country. To put this crisis into perspective, LAC+USC Medical Center provided over 66,000 inpatient admissions, 13,644 live births, and close to 700,000 outpatient and emergency room visits in 1993. Ninety-four percent of their inpatient admissions and 85% of their outpatient and emergency visits were for Medicaid patients and the uninsured. From any perspective, the closure of this institution would be a major disaster for the County's entire health system, not just the Medicaid program. And yet this is only one of a number of safety net health systems around the country that could face similar action if budget reductions of the size and scope of those proposed in the Budget Resolution are ultimately implemented.

Part III of my testimony provides an estimate of the possible impact on these essential providers of reductions in Medicaid and Medicare on the magnitude of those in the Congressional Budget Resolution. Let me first share with you a few statistics about the volume (and financing) of uncompensated care and community-wide services provided by these health systems. The tables described are attached at the end of my testimony.

Table 1 identifies the source of gross revenues for NAPH member hospitals in 1993, and indicates that 88% were attributable to Medicare, Medicaid or self-pay patients.

Table 2 provides the same breakdown for outpatient and emergency room visits.

Table 3 identifies both the total volume of inpatient services and outpatient/emergency room visits provided by 13 of the larger NAPH member hospitals, and indicates that the substantial proportion of those services that are not compensated by Medicare, Medicaid or any other third party payer. In summary, these 13 hospitals alone provided over 6.7 million outpatient department/emergency room visits, of which over 3.2 million (or 45%) were uncompensated.

Finally, Table 4 provides nearly 50 examples of the kinds of additional—often unfunded—services provided by these essential providers. While some of these services are more likely to be required by low income patients, many of them are provided to all residents of the community, regardless of income status and ability to pay. These services (and the vulnerable populations in need of them) were described in detail in a 1994 NAPH publication prepared to educate members of Congress and the public on the identity and needs of Vulnerable Populations. A copy of this publication has been submitted with my testimony, and additional copies can be made available.

In the absence of system-wide health reform or universal coverage, both this extraordinarily high volume of uncompensated care, and these dozens of unfunded community-wide services, can only be funded through maintaining reasonable levels of Medicaid support, augmented by the kind of institutionalized "cost shifting" represented by DSH and medical education payments.

II. Genuine Medicaid reforms, whether through block grants or otherwise, will be virtually impossible to achieve in the context of nearly half a trillion dollars in Medicaid and Medicare spending reductions.

As we celebrate the 30th anniversary this week of the establishment of Medicaid and Medicare, it is important to pause and recognize the unsurpassed contribution that these landmark initiatives have made to the health of America's elderly, disabled, children and indigent. From our vantage point on the front lines of providing care to these vulnerable populations, NAPH members are daily witnesses to the positive impact these programs have had on their beneficiaries.

Despite rhetoric to the contrary, these programs have achieved their results for the most part efficiently and economically. With the explosive recent growth in Medicaid DSH payments now ended, current projections for growth in the Medicaid program are largely due to demand for long term care and the growth in the number of recipients. Even with the Medicaid program in place, however, over 40 million Americans remain without coverage, and as noted above, a significant proportion of the care needed by these individuals is also being funded at least indirectly by Medicaid and Medicare, through DSH and medical education payments. It is therefore simply impossible for most analysts to imagine reducing Medicaid spending by $182 billion over 7 years without seriously jeopardizing the delicate balance on which America's health care delivery system currently rests.

The impact of the proposed reductions on essential providers is stark. In the year 2002, the Medicaid expenditure reductions envisioned in the budget resolution are estimated to result in 30 percent less Medicaid spending, which would translate into a loss of 11 percent of total operating revenues for NAPH members. The impact on the communities that these hospitals serve would be dramatic. Preliminary NAPH analysis shows that in the year 2002, Medicaid revenues to 92 NAPH health systems would be reduced by $4.6 billion. Over the 7-year period the reductions would total $15.3 billion, which is the equivalent of one-and-a-half years of Medicaid revenue. These losses cannot help but translate into reduced services, not only for the poor, but for entire communities as hospitals will be faced with the prospect of curtailing the accessibility for all Americans to a wide range of expensive tertiary services such as neonatal intensive care, trauma care, burn care, and emergency psychiatric care.

Therefore, because of the devastating impact of the $182 billion reduction not only on direct Medicaid recipients, but on the health care delivery system as a whole, we urge Congress to reconsider both the magnitude and the speed with which the savings are to be achieved.

Despite our concerns about the budget resolution, however, NAPH agrees that some Medicaid reforms are necessary, and that program growth must be restrained. We offer the following observations:

While we strongly oppose a cap on overall growth, Medicaid spending growth could be limited on a *per capita* basis to take into account future fluctuations in need. Per capita spending limits could be implemented along the lines recommended by the bipartisan Entitlement Commission. Through such caps, it may be possible to achieve the $55 billion in Medicaid savings envisioned in the President's budget proposal without decimating the program. If caps are placed on Medicaid growth, even on a per capita basis, they should be phased in much more gradually than in the budget resolution. Medicaid growth has already slowed dramatically—from 19 percent to 10 percent annually. Disproportionate share hospital (DSH) payments have been capped. Most of the recent growth has been in enrollment, with the focus on children and the elderly. Medicaid now covers nearly 30 percent of all children and 13 percent of the elderly, versus just 5.5 percent of adults aged 21 to 64. We do not want to see backsliding in coverage for these vulnerable populations.

NAPH opposes any "block grant" approach that would permit states to eliminate the entitlement nature of Medicaid or reduce support for essential providers of care for the poor. These efforts represent an about-face from the direction even many Republican proposals took last year, which was to increase not decrease health coverage. The number of uninsured would likely increase substantially in many states under such a proposal, and safety net hospitals and other essential providers would be flooded with newly-uninsured patients, on top of an already large burden of uncompensated care.

Block grants, and elimination of the Medicaid entitlement, would also effectively act as an unfunded mandate on local governments. Because public hospitals will continue to have a "service" mandate to treat the uninsured, local governments who subsidize these institutions will experience the spending reductions as an unfunded mandate. At a time when Congress is trying to devolve control to localities, imposing such a huge new fiscal burden on our counties and cities will only serve to tie their hands and limit their flexibility.

III. To ensure that a minimal safety net is preserved to serve the poor, the disproportionate share hospital adjustment program should be retained, with more careful targeting on high volume providers of Medicaid and indigent care.

In 1981, Congress established the Medicaid disproportionate share hospital (DSH) program for the purpose of providing additional reimbursement for hospitals serving large numbers of low income uninsured and Medicaid patients. Throughout the early and mid-1980s, the program was relatively small, but in the late 1980s and early 1990s, DSH payments grew exponentially due primarily to creative financing mechanisms used by states to draw down large federal matching payments. Consequently, total DSH spending (federal and state) rose from less than $1 billion in FY 1989 to over $17 billion in FY 1992.

NAPH agrees with GAO and other analysts that only part of this amount is actually being paid to those hospitals serving high volumes of Medicaid and uninsured patients, as originally intended. According to an NAPH survey, 95 NAPH member hospitals (including most of the largest public hospitals in the country) received a total of $4.3 billion in Medicaid DSH payments in 1992, or approximately 25 percent of the total $17 billion spent. The $4.3 billion is a gross number, however. Most states finance the non-federal share of their DSH programs through intergovernmental transfers or provider taxes—in other words, with funds provided by the recipient hospitals. Therefore, the real benefit to the hospitals must be viewed on a net basis, after subtracting the taxes and transfers supplied by the hospitals. We found that the 95 survey hospitals retained only $2.0 billion of the $4.3 billion in gross payments. Admittedly, there are other high-volume DSH providers who are not NAPH members and were therefore not included in the survey. Nevertheless, even accounting for these hospitals, we estimate that only about $6 billion in federal funding was really used to assist hospitals caring for those patients for whom the program was created.

Despite the abuses in the program, it has nevertheless provided crucial funding for hospitals that truly do serve a disproportionate share of indigent and Medicaid patients. This funding has enabled these hospitals to continue to act as an institutional safety net for those with no other access to health care, and to provide highly specialized services that are relied upon by entire communities.

With the spending reductions mandated by the budget resolution, cutbacks in Medicaid eligibility, benefits and provider payments are going to mean that supplemental DSH funding for safety net institutions is going to be more important now than ever. It is these hospitals that are going to be called upon to serve those who find themselves newly without coverage. It is these hospitals that will be most likely to agree to serve Medicaid patients in the face of ever-declining reimbursement. In short, these are the hospitals that will be the backbone of the health care delivery system for America's poor, and we must ensure that their viability is not jeopardized, because no one else will be there to take their place if they go away.

For these reasons, whether or not a block granting approach is adopted, *NAPH urges the Committee to retain and reform the DSH program by targeting payments on those hospitals that are truly high volume providers of care to Medicaid and uninsured patients.* A targeted DSH program can be designed to complement any system of Medicaid reform: block grants, per capita caps or otherwise. The point is to ensure, in a world of vastly diminished public resources for essential providers, that a core group of safety net institutions remain able to carry out their traditional mission of serving those in society with nowhere else to turn.

IV. With respect to managed care, we must be careful not to overpromise and overexpand, beyond the capacity of our health system to respond.

The term "managed care" is now so ubiquitous that it dominates the field of vision in both the private and public sectors of our nation's health industry. More than just a helpful tool, managed care has become a preoccupation—perhaps even an obsession—for private insurers, employers, and individuals, as well as for legislators and bureaucrats at every level of government. Yet it is an obsession that obscures the need for greater scrutiny of the managed care industry, in order to avoid potentially irreversible damage to the future viability, quality and ethical standards of health care providers, as well as to the good health of many millions of Americans.

In other words, before we continue this headlong rush into uncharted territory, we need to pause and take stock, to make sure our moral compass is working properly. We need to ask (and answer) some tough questions in the heat of the current debate, which I believe represents nothing less than a struggle for the reputation, ethics, values, even the soul, of the managed care industry.

The dilemma is essentially a simple one: What is "managed care"? Is it intended to be primarily a blunt instrument for containing health costs—as many policymakers in Washington and dozens of state capitols believe? Or—as some managed care advocates would like to believe—is it something else: a genuine health care delivery reform that shifts the historic emphasis from acute and episodic intervention to the prevention and maintenance of wellness?

This is not an idle question. If managed care is primarily the former—a way to contain costs—then we may be wasting our time worrying about protecting the integrity of our nation's health system. As indicated by the recent publicity over the failure of some HMOs to pay for emergency services, if the bottom line is all that counts the patient and the provider will both suffer (this is true whether the bottom line is Medicaid savings or higher stock prices and HMO executive salaries). Of course, we would all like to believe that effective managed care plans can BOTH restrain costs and improve wellness. But the plain fact is, in the public sector at least, MOST managed care activities have been carried out in the name of short term cost containment rather than genuine health system reform.

There are perhaps several ironies here. The first, of course, is that GAO and other observers have found increasing evidence that managed care is not much more effective over time in holding down health costs than the fee for service system it is rapidly supplanting. GAO found that only the most highly organized and self-contained plans—staff and group model HMOs—have any measurable track record over time in holding down costs. For most other plans, a brief initial flurry of savings can be driven by the arbitrary demands of states or other payers. However, if those savings are achieved (as noted below in the case of Tennessee) by trying to buy services with premiums that are significantly below cost, pressures build up for larger increases later or providers abandon the program. Even in the best situations, costs seem to rise for most managed care plans at about the same rate as the industry as a whole. And finally, as an article in the current issue of Health Affairs has pointed out, when adjusted for age and sex, Medicaid enrollees in HMOs cost 23 percent more than commercially insured enrollees.

A second irony is that the major underlying reasons for cost increases in the American health industry have little or nothing to do with either managed care or fee for service medicine. Rather, they depend on such factors as the large and ever-growing numbers of uninsured, continuing advances in expensive technology on both the outpatient and inpatient fronts, and the fact that no one yet has effectively cured most Americans from demanding the most and the best no matter what health plan they enroll in. (It cannot escape the Committee's notice that the so-called "point of service" managed care plans—the most costly and least controllable—usually score highest in consumer satisfaction among HMOs.)

The third, and perhaps greatest, irony is that the steps which clearly could reduce health costs over time—prevention, wellness and public health services—are the last services added and the first ones on the chopping block when the primary goals are short term cost containment and profit-taking.

Certainly, there is no disagreement about the importance of preventive measures aimed at improving both individual and community-wide health status. Preventive health can minimize both the potential for excessive care in the fee for service environment and the potential for providing too few services in the managed care environment. Moreover, the assignment of patients to primary care gatekeepers who are able and willing to manage the full continuum of a patient's care also improves a patient's health, and thus holds down long term health costs, even if more services are needed in the short run. But these features must be fully integrated into HMOs, not just grafted onto the surface. Of course, many managed care organizations and employers do try to emphasize wellness and prevention, or at least pay lip service.

The problem is, we cannot demonstrate that these services will reduce health costs overnight. In fact, in the short run their effective use is likely to increase services and costs.

Ultimately, of course, if "managed care" is seen only as a tool for cutting costs, the result will be a health system that is neither "managed" nor "care". We all know that there are more than a few dirty little secrets about the explosive growth in Medicaid managed care over the last several years. I will agree that some managed care organizations have developed elegant, sophisticated MIS and case management systems that make good use of primary care gatekeepers and emphasize prevention and wellness. Some plans may also have adequate and well-rounded networks of providers that are reasonably reimbursed and given rational incentives to change wasteful practice patterns. However, many other managed care organizations have simply grown too fast to take the time to develop such systems. Such organizations are far more likely to achieve savings (and profits) through enrolling mostly people who are young or healthy (or both); creatively investing the enormous cash flow generated by capitated payments; ratcheting down payments to providers wherever they can, while paying providers as slowly as possible; keeping overhead and support staff (including phone lines and the personnel to answer them) to a minimum; erecting other subtle and not-so-subtle barriers to access; and praying no one needs a liver transplant before they can cut a deal to sell out to one of the giant HMO companies.

Now it may sound from these statements that I oppose managed care. But nothing could be farther from the truth. I belong to an HMO. NAPH has been working rapidly to help both public and private health systems develop or expand managed care capacity all across the country. Together with my associate, Bill von Oehsen, I have just this week published a new book—a 1000 page "How To" manual for Medicaid Managed Care and State Health Reform. Managed care is not problematic in itself—especially for the poor and disenfranchised. Done properly, managed care can result in genuine improvements in health status and expansion of access for some of our most vulnerable patient populations. It is just that, done poorly, implemented too rapidly, or for the wrong reasons, it could be a setback, not an improvement, both for patients and for entire communities. And in the end, it simply cannot by itself generate the savings likely to be demanded of it, except through the arbitrary imposition of actuarially unsound premiums and below-cost provider payment rates.

We need only look at the TennCare Medicaid debacle to see some of the problems we face when cost becomes the only issue. With TennCare, the state of Tennessee dumped all Medicaid and many uninsured patients overnight into ill-prepared managed care plans with inadequate provider networks, only to pay them premiums that were originally found to be 40% below acknowledged actuarial soundness. Moreover, the record shows that the state of Tennessee *knew* that the rates were not actuarially sound, yet the state was pressured by the need to curtail the Medicaid budget, while locking in federal DSH payments vital to the entire state budget before they could be capped by the Congress. They thus went forward with TennCare despite dire predictions of chaos. As recently as last month, TennCare rates were determined by Governor Sundquist's own TennCare Roundtable to remain 10-20% below costs. And in fairness to the Governor, who was not responsible for developing TennCare, he and his staff have now publicly committed themselves to implementing needed reforms.

Nevertheless, the impact of implementing a seriously underfunded program of this scale in such a short time frame has been felt throughout Tennessee. TennCare enrollees continue to experience significant access problems in the face of inadequate provider networks. Provider willingness and ability to participate in TennCare is shrinking. The financial viability of several of the MCOs is in serious question. Only cost, not care, is being "managed" as the state has not yet implemented even minimal gatekeeping requirements. And the state's (and HCFA's) ability to enforce access and other key standards that supposedly govern TennCare is embarrassingly limited.

Moreover, the impact TennCare has had on the state's health care safety net is also disturbing for its implications outside of Tennessee. The Regional Medical Center at Memphis, an NAPH member, was faced with a $42 million budgetary shortfall in FY 1995 because of TennCare. Much of the shortfall was due to the state's complete elimination of the disproportionate share hospital and medical education programs. Although hospitals had been promised that the state would replace these programs with supplemental payments under TennCare, when the dollars started getting tight in late 1994, the first move the state made was to cut off TennCare enrollment and eliminate funding for these supplemental pools. Moreover, the Med

was (and is still) experiencing extreme difficulties in obtaining earned reimbursement from TennCare managed care organizations (MCOs).

As a result, Tennessee's largest publicly funded provider has begun closing key services, including its cancer treatment and cardiology services, and laying off hundreds of workers. They have greatly limited free services to uninsured residents of bordering states (especially Arkansas and Mississippi) and even imposed new restrictions on uninsured Tennessee residents (of whom there remain hundreds of thousands despite TennCare). The Med was faced last month with the prospect of eliminating their newborn center and discontinuing all obstetric services. At the last minute, however, a deal was reached with HCFA to inject an additional cash infusion of $12 million into TennCare for the Med (as well as for Metro General Hospital in Nashville, another safety net institution and NAPH member that was also dangerously squeezed by TennCare). While this welcome aid did not completely solve the Med's problems, it at least helped them to make it to the end of the fiscal year. Nevertheless, the serious underfunding of TennCare continues to threaten the viability of the Med and other essential providers across the state. This Committee cannot ignore the TennCare experience as you move to consider various reforms in Medicaid nationwide.

I do not believe it is inevitable that TennCare represents the future of managed care—but if we hope to expand such programs to include an even more substantial proportion of Medicaid recipients, we must act quickly, together, to set tough standards for equity, fairness, access, quality and fiscal integrity in managed care plans. In particular, I urge you to consider the following: It is essential that the federal government impose a basic minimum set of standards on Medicaid managed care organizations. These standards must include assurances of actuarial soundness for plan premiums as well as financial solvency, capital adequacy and marketing standards. Increased emphasis must be placed on developing an adequate risk adjusted capitation system that recognizes the additional costs incurred by some MCOs and providers serving particularly high risk, costly patients. Such a system must include a mechanism that ensures that risk adjustments are passed onto the providers actually incurring these additional costs, rather than simply added to the bottom line of the MCOs.

Even in a mandatory managed care system, financial support for certain safety net providers must be maintained. Even the most ambitious and well-implemented Medicaid managed care programs have not provided universal coverage, and there will always be an uninsured population that it will be up to a core group of safety net providers to serve. Moreover, neither will the need for high cost specialty services that are not adequately reimbursed through the normal channels (be it private or public, fee for service or managed care) go away. Supplemental funding for these essential providers is imperative.

As states move to implement managed care, care must be taken to implement these programs gradually and carefully, rather than overnight as was attempted in Tennessee. Overambitious implementation schedules can completely upset a state's health care delivery system, with lasting implications.

NAPH looks forward to assisting the Committee and Congress as a whole to work together on a bipartisan basis to develop rational Medicaid reforms that will achieve real cost savings without placing the health care safety net in serious jeopardy. I would be happy to answer any questions you may have.

TABLE 1

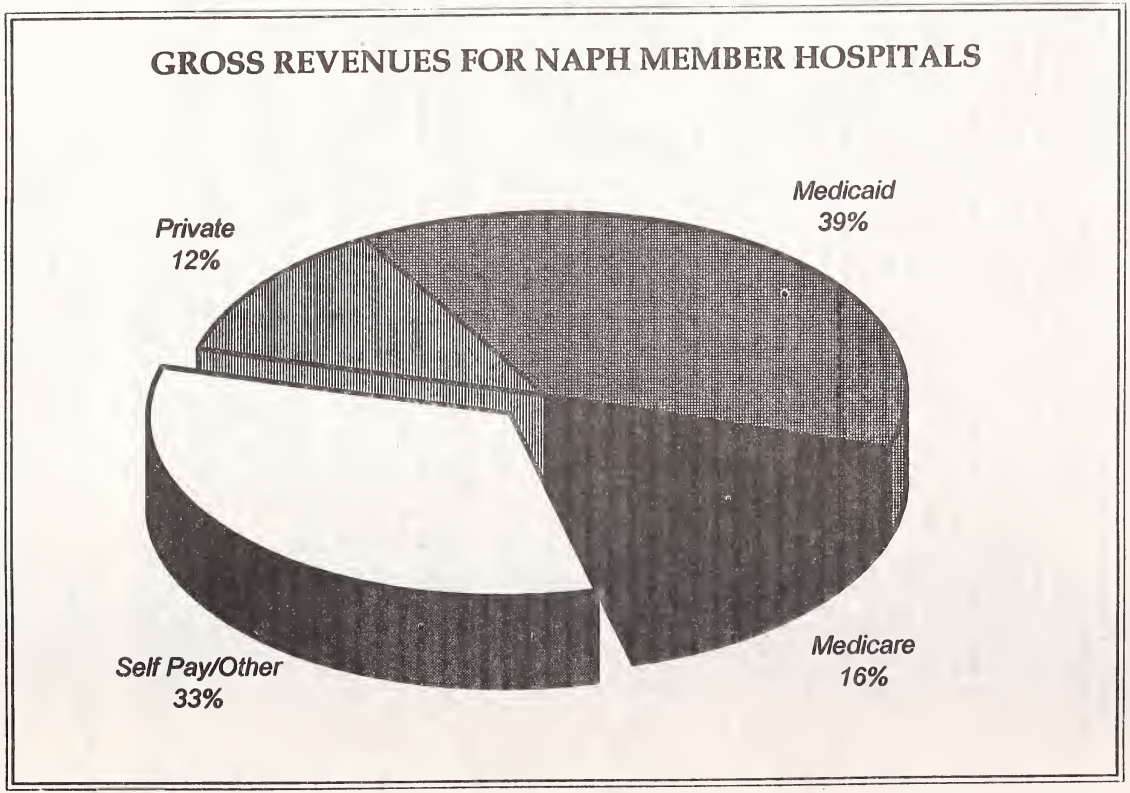

GROSS REVENUES FOR NAPH MEMBER HOSPITALS
Medicaid
39%
Private
12%
Medicare
16%
Self Pay/Other
33%

TABLE 2

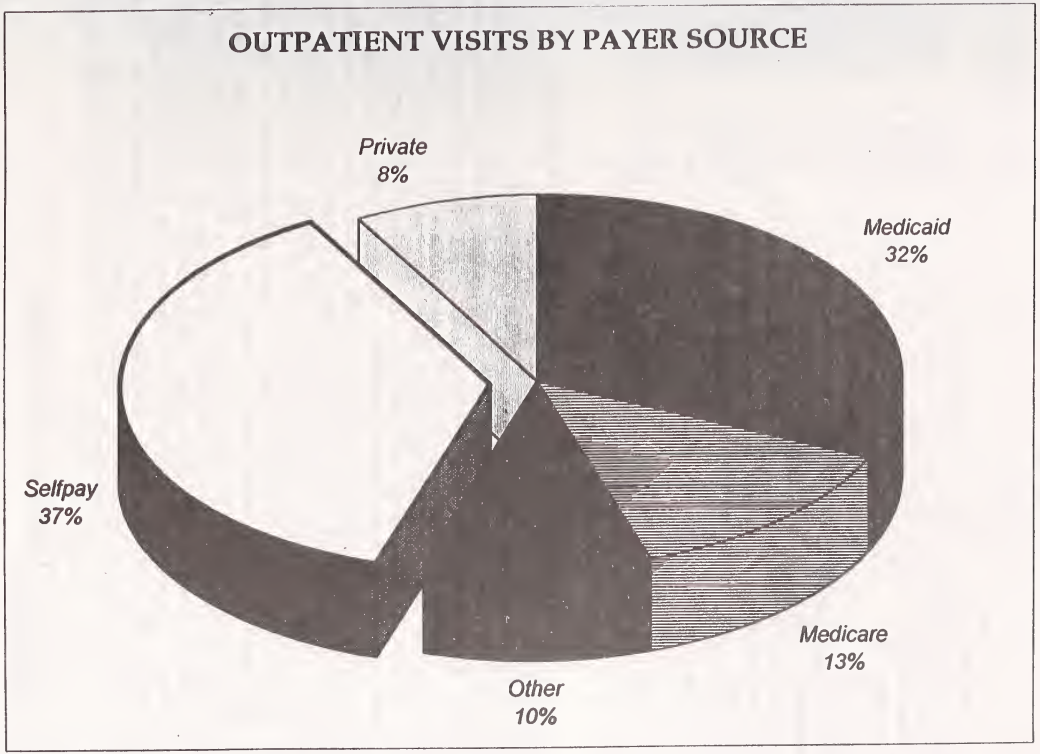

OUTPATIENT VISITS BY PAYER SOURCE
Private
8%
Medicaid
32%
Selfpay
37%
Medicare
13%
Other
10%

Table 3

Hospital Name	Uncompensated Visits	Total Outpatient/Emergency Room Visits	Percent of Visits Uncompensated
Harris County Hospital District	436,708	659,112	66%
Grady Memorial Hospital	569,084	864,733	66%
Cook County Hospital	398,570	691,465	58%
LAC+USC Medical Center	357,602	644,453	55%
Kings County Hospital	273,399	857,878	32%
Elmhurst Hospital	203,957	459,837	44%
Harbor-UCLA Medical Center	182,704	332,030	55%
Lincoln Medical & Mental Health	176,517	519,167	34%
Univ. of Texas Medical Branch Hospital	171,408	362,816	47%
Denver General Hospital	150,015	423,971	35%
Bellevue Hospital	139,490	458,202	35%
Medical Center at New Orleans	117,080	358,406	33%
Kern Medical Center	30,189	104,846	29%
Total	3,206,723	6,736,916	45%

Table 4

Uncompensated Services Provided by Safety Net Hospitals

Financial counselors; Social workers; Discharge planning; Additional security for urban providers; Translators/interpreters; Financing assistance; Prison health services; Special services for AIDS patients; Injury prevention/safety; Smoking cessation; Substance abuse diagnosis and treatment; Nutrition assessment; Nutrition counseling; Child care for children of patients; Transportation services; Longer LOS and extra service for inpatient with secondary diagnosis of alcoholism/drug abuse; Additional services for cocaine-exposed neonates; Screening/preventative care (e.g. for lead paint poisoning, hypertension, diabetes, vision, hearing); Outreach; School-based services; Management of patients at risk; Family planning; Sex education; Sanitation; Case management for elderly; Geriatric assessment teams; Extra services/dental, vision, hearing; Caregivers respite and family support; Mobile services for homeless, homebound; Communication services for patients without phones; Patient advocates; Legal assistance; Chronic disease management for the disabled; Medication management; Rehabilitation; Assistance obtaining housing; Home health care; OPD pharmacy services; Day care for disabled adults/children; Meals (emergency department/home); Special vocational education and rehabilitation; Private, negative pressure rooms with appropriate ventilation for TB patients; Trauma, burn care, neonatal intensive care and other tertiary services on 24-hour standby basis; Abused/neglected children services; Long-term care for boarder babies; Parenting classes; Birth centers; Coordinated volunteer services; Specialized clinics; Patient education centers; Money management/life skills training; and Cultural sensitivity training for physicians and other staff.

Mr. BILIRAKIS. Thank you, Mr. Gage.

Mr. DeBrunner.

STATEMENT OF CHARLES DeBRUNNER

Mr. DEBRUNNER. Thank you, Mr. Chairman and members of the committee. I am the Director of Federal Affairs for the Urban Health Care Coalition of Pennsylvania. I am here on behalf of Martin Goldsmith who is the President and Chief Executive officer of the Albert Einstein Health Care Network, which is located in Philadelphia and is also the president of the coalition.

The Urban Health Care Coalition of Pennsylvania is an association of hospitals in Philadelphia and Allegheny Counties that provide significant amounts of care to the poor and elderly and especially to Medicaid. Although we are opposed to significant reductions in the Medicaid. Although we are opposed to significant re-

ductions in the Medicaid program, we acknowledge that the current environment and the passage of the budget resolution makes the cuts almost a foregone conclusion. These Federal reductions, if done in an indiscriminant and haphazard manner may very well jeopardize the existence of hospitals such as the ones in our coalition. The same institutions that provide most of the care to the poor in their urban communities.

However, it is our belief that a well-crafted block grant proposal can possibly obtain the savings you seek in eliminating the Federal deficit and fulfill the Medicare program's original intent, which is to serve the health care needs of those who can't help themselves.

The creation of a Medicaid block grant program, a revolutionary idea on a scale never before attempted will involve a lot more than simply cutting the strings. For this reason, we would like to outline what we believe are the major obstacles to creating a Medicaid block grant program and then we would like to offer some recommendations on how to address those problems so that this approach can work efficiently, effectively and with a minimum of subsequent Federal involvement.

The possibility of a change to a Medicaid block grant program poses considerable challenge to the States that pay for health care services for the poor and to the hospitals that provide those services. Of critical importance to the program's success is the design of a funding formula. The potential pitfalls are evident if the distribution of the Federal funds is based only on the number of poor people in a State, States with more comprehensive Medicaid programs such as Pennsylvania could be left with insufficient funds to continue to serve its current eligible population. On the other hand, an allocation based solely on a State's historical payments could leave States vulnerable to financial harm during periods of increasing numbers of eligibles.

In putting the States at risk, this approach also puts providers, especially hospitals and therefore the inner city poor at risk as well. If the State find themselves with rising Medicaid costs and declining Federal participation, they could be left with four extremely difficult options for managing their program's finances and reducing their costs.

First, they could change their eligibility criteria to allow fewer people to receive Medicaid benefits but this would reduce access to care for the poor and increase the burden on an already overburdened urban hospital to provide uncompensated care to the poor and the uninsured.

Second, States could reduce their payments to providers of Medicaid services. Because we provide more Medicaid services than other hospitals, our losses would be enormous and devastating.

Third, States could reduce or eliminate Medicaid disproportionate share payments. This too would have a devastating impact on urban hospitals. Disproportionate share payments are vital to us, reimbursing us in part for the large number of uninsured patients we treat.

Fourth, States could reduce or eliminate medical education payments. Medical education payments financed highly efficient, cost-efficient deliveries of care but those economies could be lost amid future erosion of medical education payments.

Any of these State proposals could very well upset the delicate balance in which urban hospitals such as ours exist. Hospitals such as those in the coalition are typically the only providers of care in their communities and play a critical role not only in the wellbeing of the sick individual but often a life or death role in the community as well. These potential consequences cannot be ignored.

We believe that a carefully crafted block grant program can not only slow the growth of the Federal Medicaid spending but can provide adequate resources and safeguards to meet the future health care needs of our Nation's poor and elderly. The coalition therefore urges you to create a block grant program that maintains the historic Federal commitment to the poor, provides for adequate protection for future growth in the program and enables all States to operate an effective Medicaid program that meets the needs of the poor and the providers that serve them.

We believe that an equitable block grant program must contain the following provisions. First and foremost, we believe the formula for the block grant program should be responsive to the fluctuation of people who are eligible, funding the States based on per capita payments linked to a minimum Federal eligibility standard.

Second, the formula must not reduce Federal contributions to the States below current levels. A formula which cuts back on the Federal contribution jeopardizes the quality of health care services already being provided to the poor by the States and puts the integrity of the States' program at risk.

Third, we believe that a successful block grant initiative must incorporate an adequate rate of growth in Federal Medicaid spending to deal with the rising costs that providers must pay for the goods and services necessary to deliver care.

Fourth, we urge you to recognize that the costs we incur for caring for the poor and uninsured, by requiring the continuation of adequate disproportionate share and medical education payments. The mechanism that you employ to do this does not necessarily need to look like the Medicaid disproportionate share and medical education systems that we all know today but it should have the same objective, at least for hospitals such as ours that serve exceptionally large, poor inner city communities.

And, fifth, we urge you to require that States spend all of their Federal Medicaid block grant money on health care services for the poor. They should not be able to use it for any other purpose.

In conclusion, we recognize that balancing the budget is one of your main priorities and as taxpayers we share that concern and we respect the process you are undertaking. But, as you reduce spending, we hope that you will keep in mind how those cuts might affect some of the same constituents, not only the poor but also the middle class people who use our hospitals and their elderly parents who need Medicaid to pay for their long-term care.

We are ready to assist this committee and Congress in crafting a Medicaid block grant program which provides predictability in future funding for the Federal Government, flexibility in providing services for the States, continued accessibility to health care services for urban populations and stability to our Nation's urban hospitals.

Thank you.

[The prepared statement of Martin Goldsmith was received for the record:]

PREPARED STATEMENT OF MARTIN GOLDSMITH, PRESIDENT, URBAN HEALTH CARE COALITION OF PENNSYLVANIA

Good afternoon. Mr. Chairman, members of the committee, and guests, my name is Martin Goldsmith. I am president and chief executive officer of the Albert Einstein Healthcare Network, located in Philadelphia. I am here today in my capacity as president of the Urban Health Care Coalition of Pennsylvania to talk to you about the proposal before this committee to convert Medicaid from an entitlement to a block grant program.

THE URBAN HEALTH CARE COALITION OF PENNSYLVANIA

The Urban Health Care Coalition of Pennsylvania is an association of hospitals in Philadelphia and Allegheny Counties that provide a significant amount of care to the poor, those with low incomes, and the elderly. Generally, these hospitals have at least 150 beds, and 12% or more of their revenue comes from Medical Assistance, Pennsylvania's Medicaid program. Membership is also open to other urban hospitals in Pennsylvania that rely heavily on government programs for support.

The Role of the Urban Hospital

Like urban hospitals elsewhere, the members of the Coalition occupy a central position in their communities—and their influence extends throughout Pennsylvania. They are hubs of medical treatment for tens of thousands of persons of all descriptions, and many of them specialize in areas of care—pediatrics, drug and alcohol rehabilitation, gene therapy, brain trauma, women's health, organ transplants, and others—that attract patients from far beyond their immediate service areas. Future physicians, nurses, technicians, and researchers receive their training at Coalition hospitals and then put that training into practice in every corner of Pennsylvania. Urban hospitals are also among the major employers in their communities and are the foundation of the state's vital health-care industry.

The Urban Poor

The living conditions of Pennsylvania's urban poor are far different than those of the state's other residents. Unemployment and crime rates are higher; educational achievement is lower. Cultural and language barriers create pockets of isolation.

The health-care environment of the urban poor mirrors their social environment. In urban Pennsylvania, poor, unmarried, and teen-aged women are more likely to have babies, more likely to receive little or no prenatal care, and more likely to see their children die during the first year of life. The poor are less likely than the average Pennsylvanian to see a doctor regularly and are more likely to die from stroke, cardiovascular disease, heart disease, lung cancer, breast cancer, and AIDS.

Because relatively few doctors practice in poor urban neighborhoods, the residents of these neighborhoods go where the doctors are: to hospital emergency rooms and clinics. Its residents are highly dependent on our hospitals and government insurance. In turn, urban hospitals have become highly dependent on government programs like Medicaid and Medicare to compensate them for the services they provide, and many receive from fifty to ninety-five percent of their revenue from government.

Pennsylvania's Medicaid Program

Medical Assistance, Pennsylvania's Medicaid program, is the cornerstone of the state's effort to provide health care for the poor. The Pennsylvania Department of Public Welfare's $6.3 billion Medical Assistance budget makes Pennsylvania state government one of Pennsylvania's largest purchasers of health care. There are 675,000 Medical Assistance recipients in Allegheny County and Philadelphia, and a substantial number of them are served by Coalition hospitals.

Medical Assistance is a program of critical importance—and a program that faces critical problems. The program is already underfunded: on the whole, Medical Assistance reimbursement is well below the cost of providing care. As a result, many physicians—especially primary-care physicians and specialists with non-hospital practices—decline to participate in the program. This in turn has meant that hospitals must assume an even greater share of the responsibility for caring for the poor.

The Coalition's Mission

Coalition hospitals are on the front line of Pennsylvania's Medical Assistance program. They care for thousands of Medical Assistance recipients daily, and they have

been doing so for many years. They have a firsthand understanding of the issues with which the program must contend in the months and years ahead, and of the overriding challenge facing the state and federal governments: to provide quality health care services for the poor but to make these services available in the most effective, least costly manner possible.

How this challenge is addressed will have a profound impact on the future of urban hospitals, because where the health of the poor is concerned, government and urban hospitals act in partnership: government depends on the hospitals to deliver the necessary services and the hospitals depend on government for the resources to do so.

The Coalition's mission is to make this partnership an even closer one. It works with government at all levels to develop and implement innovative responses to some of Pennsylvania's most pressing health-care issues, particularly those affecting Medical Assistance and other programs that serve the poor. Although its focus is on Medical Assistance, the Coalition is involved in other health-care matters that affect the residents of the communities that its members serve, including health-care reform and health planning, the governance of managed care, and insurance and tax laws. The Coalition also addresses relevant social issues—welfare, crime, substance abuse, education, unemployment, and others—as the need arises. The Coalition's mission is to speak for its constituency—the people who turn to Pennsylvania's urban hospitals for care—and to take an active interest in whatever affects their health and well-being.

OUR VIEWS ON MEDICAID BLOCK GRANTS

Although we are opposed to significant reductions in the Medicaid program, we acknowledge that the current environment and the passage of the Budget Resolution make the cuts a foregone conclusion. These federal reductions, if done in an indiscriminate and haphazard manner, may very well jeopardize the existence of hospitals such as ours— the same institutions that provide most of the care to the poor in their urban communities. However, it is our belief that a well-crafted block grant proposal can not only obtain the savings you seek in eliminating the federal deficit but also fulfill the Medicaid program's original intent—to serve the health care needs of those who can't help themselves.

Making Block Grants Work

As anyone connected with Medicaid will tell you, this federal-state program is extremely complicated and intricate. As such, the creation of a Medicaid block grant program, a revolutionary idea on a scale never before attempted, will involve a lot more than simply 'cutting the strings'. Many facets need to be considered before an equitable, successful proposal can be enacted. For this reason, we would like to spend a few minutes outlining what we believe to be the major obstacles to creating a Medicaid block grant program, and then, we would like to offer some recommendations on how to address those problems so that this approach works efficiently, effectively and with a minimum of subsequent federal involvement.

Obstacles to Overcome

The possibility of a change to a Medicaid block grant program poses a considerable challenge to the states that pay for health care services for the poor and to the hospitals that provide those services.

This approach would give states a significant opportunity to exercise unprecedented control over their Medicaid programs—over the services to be covered, eligibility for coverage, and the manner in which services are delivered. In so doing, however, this also puts states at great responsibility for how they use that control and spend their federal money.

A key consideration will be how the federal government adjusts its Medicaid block grants in the future. In present terms, in order to maintain the stability and viability of current state programs, states should be provided with, at a minimum, level funding based on current allocations. Down the road, as long as the federal government's future contribution is reasonably responsive to changes in the national economy and rising health care costs, block grants could work.

The design of the formula is, therefore, fundamental to the success of Medicaid block grants. The potential pitfalls are evident. If the distribution of the federal funds is based only on the number of poor people in a state, states with more comprehensive Medicaid programs such as Pennsylvania could be left with insufficient funds to continue to serve its current eligible population. On the other hand, an allocation based solely on a states historical payments could leave states vulnerable to financial harm during periods of increasing numbers of eligibles.

In putting the states at risk, this approach also puts providers, especially hospitals and therefore the inner city poor, at risk as well. If states find themselves with rising Medicaid costs and declining federal financial participation, they could be left with four extremely difficult options for managing their programs' finances and reducing their costs:

- First, they could change their eligibility criteria to allow fewer people to receive Medicaid benefits, thereby saving money. This would increase the burden on already over-burdened urban hospitals to provide uncompensated care to growing numbers of poor and uninsured people in our communities. It may also lead to reduced access to care for the poor.
- Second, states could reduce their payments to providers of Medicaid services. This, however, would have a devastating impact on urban hospitals. Underpaying us for the services we provide to a significant number of our patients jeopardizes our ability to continue to serve the low income populace.
- Third, states could reduce or eliminate Medicaid disproportionate share payments. This, too, would have a devastating impact on urban hospitals. Disproportionate share payments are vital to us, reimbursing us in part for the large numbers of uninsured patients we treat and recognizing the increased costs in providing health care in inner city communities.
- Fourth, states could reduce or eliminate Medicaid medical education payments. As with disproportionate share payments, this would have a devastating impact on our hospitals. Medical education payments finance highly cost-efficient delivery of care, but those economies could be lost amid future erosion of medical education payments. Also, without medical education payments, or with reduced medical education payments, it may become virtually impossible to get doctors to practice in the inner city in the future. When doctors train in cities, there is at least a chance that they will choose to stay and practice medicine, but if they train in the suburbs, they are unlikely to decide to set out a shingle in an inner-city community when their training is finished.

The Potential Loss of Urban Health Care

Any of these state proposals could very well upset the delicate balance in which urban hospitals such as ours exist. Hospitals such as those in the Coalition are typically the only providers of care in their communities and play a critical role not only in the well-being of the sick individual but often a life-or-death role for the community as well.

As we consider how to improve Medicaid, we should not lose sight of why it was introduced in the first place: to help those who cannot help themselves. Turning Medicaid into a block grant program—without proper safeguards—would seriously threaten those hospitals who've chosen to deliver the critical care in the inner cities where many of the poor live.

"Unfunded Mandates" Versus "Unmandated Funds"

Finally, amid all of the recent talk about unfunded mandates, the Urban Health Care Coalition of Pennsylvania is concerned that in attempting to address this legislative concern, Congress may be moving too far in the opposite direction. While you do not want to impose unfunded mandates, neither should you provide unmandated funds. Even with the proposed reductions in Medicaid funding, the federal government would continue to provide an enormous amount of money to the states for health care for the poor. In return for receiving this money, the states should be required to spend all of this money—*every single dime of it*—on Medicaid services for the poor. They should not be able to cut corners to save money so they can spend it instead on schools, prisons, housing, or any other purpose, no matter how worthy.

OUR PROPOSAL FOR MEDICAID BLOCK GRANTS

The Coalition believes that a carefully-crafted block grant program can not only support slowing the growth of federal Medicaid spending, but also provide adequate resources and safeguards to meet the future health care needs of our nation's poor and elderly. The Coalition, therefore, urges you to create a block grant program that maintains the historic federal commitment to the poor, provides for adequate protection for future growth in the program, and enables all states to operate an effective Medicaid program that meets the needs of the poor and the providers that serve them.

We believe that an equitable block grant program must contain the following provisions:

First and foremost, we believe the formula for the block grant program should be responsive to the fluctuation of people who are eligible, based on a minimum federal

eligibility standard, and should accordingly fund states on a per capita basis. Under the Coalition's proposal, federal funds for Medicaid appropriations would be set aside into a separate dedicated fund for disbursement to states. The disbursement formula would allocate these funds to states based on the amount the state received per person in a selected base year plus an annual inflation adjustment rate. In addition, the formula would provide for a concomitant change in disbursements in each state based on fluctuations in the number of eligibles in each state as defined by a federal standard. However, the entire fund may not necessarily be disbursed to the states in any given year. Any remaining funds will provide a cushion to protect for future growth in the number of eligibles.

Second, the formula must not reduce federal contributions to the states below current levels. Although no state would ever claim to be thriving on the Medicaid program, they are providing adequate health care services to their low-income populations at the current dollar amount provided by the federal government. A formula which cuts back on the actual federal contribution jeopardizes the quality of health care services provided to the poor and puts the integrity of the state's program at risk. While, as mentioned above, an increase in funding should correlate with an increase in the number of low income people, no state should get less than what it gets now. In short, some version of a 'hold harmless' provision should be included in the formula.

Third, we believe that a successful block grant initiative must incorporate an adequate rate of growth in federal Medicaid spending to deal with the rising costs that providers must pay for the goods and services necessary to deliver care.

Fourth, we urge you to recognize the costs that we incur caring for the poor and uninsured and educating medical professionals by requiring the continuation of adequate disproportionate share and medical education payments. The mechanism that you employ to do this does not necessarily need to look like the Medicaid disproportionate share and medical education systems that we all know today, but it should have the same objective—at least for hospitals such as ours that serve exceptionally large, poor, inner-city communities. To ensure that federal funds designated for such a purpose actually reach the hospitals for which they are intended, you might even consider making those payments directly from the federal government to qualified hospitals instead of routing the money through the states.

And fifth, we urge you to continue providing at least some direction to the states about how to spend the billions you would continue to give them for Medicaid. While you do not want to impose unfunded mandates, neither should you provide unmandated funds. At a minimum, we ask you to require states to spend all of their federal Medicaid block grant money on health care services for the poor. They should not be able to use it for any other purposes.

In conclusion, we recognize that you believe that you have a mandate to reduce federal spending. As taxpayers, we share that concern, and we respect the process you are undertaking now and know that cuts are coming. We know that this is something that many of your constituents want you to do. But as you make these cuts, we hope that you will keep in mind how those cuts might affect some of these same constituents—not only the poor, but also the middle-class people who use our hospitals and their elderly parents who need Medicaid to pay for their long-term care.

You have a difficult task before you, and all we ask is that you take the time to understand—to truly understand—the implications of each individual action that you are about to take. We are ready to assist this Committee and Congress in crafting a Medicaid block grant program which provides predictability in future funding for the federal government, flexibility in providing services for the states, continued accessibility to health care services for urban populations, and stability to our nation's urban hospitals.

Mr. BILIRAKIS. Thank you, gentleman.

Dr. Ganske.

Mr. GANSKE. Thank you, Mr. Chairman, and thank you to our guests for being the caboose at the end of the day. Maybe we all ought to get up and do some exercises or aerobics, I don't know.

Many States are moving toward managed care. For Medicaid, we have examples like Tennessee. Are your organizations working with the State legislatures or are you devising patient protection plans?

Mr. GAGE. We are working all over the country with not just our own members, many of whom are owned by cities or counties. Some

are owned by State governments, some are nonprofit inner city hospitals. But also with States.

And we are working with them to try to implement managed care. We see some success stories in that regard and I think you heard about some of those earlier today, places like Minneapolis, Seattle, some parts of California where there is a history of managed care. We also see some horror stories.

The problem we see today with managed care, it is sort of like great burgundy wine, there is an awful lot more of it being sold than made. That's what happens at the end of the afternoon.

We have a lot of concerns about managed care and there need to be imposed a number of standards. I think they need to be Federal standards imposed on States and States need to be imposing standards of their own to try to guarantee the stability and the availability of adequate provider networks, the financial stability of managed care organizations and we have a number of those concerns and recommendations spelled out in our prepared testimony.

Mr. GANSKE. Many of your hospitals, I think, would probably be associated with university centers as components of a teaching program, is that not correct?

Mr. GAGE. Yes, about 90 percent of our members are major teaching hospitals, yes.

Mr. GANSKE. And just to follow up on the managed care aspect, it seems to me that your funding primarily is coming from Medicare and Medicaid, and that you are picking up a lot of patients without insurance or the indigent. The teaching hospitals and the university hospitals traditionally have been reimbursed through private insurance. Now we are seeing a movement away from or a restriction on access to university centers because of managed care. That is my impression. Do you think that that is reality?

Mr. DEBRUNNER. We think there is certainly a press away from the high-cost structure of university hospitals, pediatric hospitals, a variety of specialty kinds of hospitals when managed care comes into play.

In the old days, you would try to spread the cost of care among a large number of people in the university hospital or the children's hospital and consequently the cost of those very special things that those hospitals do got spread across some of the not-so-special things those hospitals do than then the cost per person is significantly higher than their competitors.

What we are seeing now at the beginning stages of managed care is to begin to take the routine care away, the typical routine care kinds of things, for example, tonsillectomy being directed away from a children's hospital somewhere else because of the difference in the cost, which only makes the very special cases much more costly as the specialty hospitals begin to try to cope with the reduction in volume.

Mr. GAGE. I think, just to add briefly, managed care and medical education don't always mix very well. It is not just the high cost of teaching hospitals, it is the need for medical educators to pay attention to a variety of missions and cost containment and even patient care itself is not necessarily the only mission, educational mission. And balancing those is important but often interferes with the need to provide high volumes of primary care, for example.

Many of our public hospitals do have high volumes and do provide a lot of primary care, but they don't do that in a teaching setting until they have to balance these missions even within their own systems.

I think what we found is that while it has taken some time, most major medical schools now I think understand that they need to be players in this ballgame whereas in the past managed care companies have come along and tried to pick the tertiary or specialty services they need on an ala carte basis. I think you find more university teaching hospitals and large, public hospitals forming their own organizations and going out and acquiring the primary care that they need to be players and to be complete delivery systems, but this is not happening over night.

Mr. GANSKE. Let me just finish up by saying that I suspect that if you receive the same dollar amount but we eliminated a lot of the strings or restrictions, that you would have some suggestions on how you would change the way that you spend those funds at your individual institutions. I mean, I have seen the mandates that have been imposed.

I would be interested if you have some specific suggestions on how to change the current system. I hope you can provide those for me, specifically as they relate to the urban hospitals.

Thank you.

Mr. BILIRAKIS. Thank you, Dr. Ganske.

Mr. DeBrunner, Mr. Greenwood represents an area outside of Philadelphia. He is not here. He was here earlier today and you probably have seen him. But he is a very, very active, important part of this subcommittee so he has been involved in all of our Medicare discussions, I might add. He is a member of the Medicare/Medicaid task force of just eight people, not counting the Speaker. Although he doesn't have any direct involvement in Medicaid, this is the only committee with jurisdiction for Medicaid. So he will certainly do the best he possibly can for Pennsylvania in general. No miracles promised, obviously.

You know, Medicaid spending has been exploding, nothing new, growing at an average annual rate of 19.1 percent, 19.1 percent between 1990 and 1994. During 1991, the outlays grew by 27.8 percent and they grew another 29.1 percent in 1992 and we can go on and on.

You know, this is a very difficult position to be in, but it is this past history that has brought us to this particular point. Is there a better way to go about it all than block grants? I don't know. I mean, the point of the matter is that something has got to be done, there have got to be changes made, and when you make changes or when you propose changes, you are always going to get opposition because people fear the unknown, and concerns have been voiced here by all of the witnesses. It comes from their heart and they mean it.

And we are just as concerned as you are and we are just as concerned as they are.

I will tell you, I don't know that it is necessary, but you may know that in a base year 1995 the expenditures, Medicaid expenditures were $156.5 billion. Now, if we stayed at that figure over 7 years, we would come out to a little over $1 trillion, $1.096 trillion

spent on Medicaid over the next 7 years based on that 1 year on the current year's figure, current fiscal year figure. But, as you may know, under the budget resolution, as horrible as it is, the dollars budgeted are $1.356 billion, an increase of $260 billion over that 7 years. So you know we are not cutting, we are reducing the rate of increase over the next 7 years because of past history.

And I think you would be the first ones—and you have said it basically in your testimonies that you agree that we have got to do something about the budget. We just can't keep it up and the trouble, the thing that we face, of course, in Medicaid and Medicare is if we continue as we are now going maybe in general people will be happier, people might be a little less fearful.

But not too long from now, it goes from fat to zero. That's the concern that we have, and that's the responsibility that we have here, and we are hopeful that with God's help and with yours, we are going to come up with something which is certainly not going to hurt the program, not going to hurt the quality of medical care and not going to hurt the medical care for the poor, especially. We are working awfully hard toward that end.

Anyhow, having said all of that, I won't ask you any questions. I will quit while I am ahead.

Thank you so very much for being here. You have helped an awful lot.

This hearing is now adjourned.

[Whereupon, at 3:17 p.m., the hearing was adjourned.]

[The following statements were submitted for the record:]

PREPARED STATEMENT OF JAMES L. SCOTT, PRESIDENT, AMHS INSTITUTE

Mr. Chairman and members of the Committee, the AmHS Institute is pleased to submit this statement for the record for the Committee's hearing on Medicaid reforms. The AmHS Institute is the public policy center for American Healthcare Systems. AmHS is a national alliance of forty of our nation's premier integrated multi-hospital systems. AmHS and its subsidiaries operate insurance, purchasing, quality assurance and marketing programs that strengthen its shareholder's ability to provide integrated health care services more effectively and efficiently. These systems own, lease, or manage nearly 400 hospitals and have affiliation agreements with over 600 other hospitals. AmHS shareholders employ over 280,000 people and generate $38 billion in annual revenues.

In this testimony, we would like to:

- Review background on Medicaid, and the very different three major components that make up the Medicaid "program"; and,
- Present our approach for reform in each of those three components, including long-term directions and specific, short-term action steps.

Background

Medicaid is a federal-state program that finances acute and long-term care services for certain low income individuals and families. In 1995, Medicaid will serve approximately 36.8 million individuals who are aged, disabled, pregnant women, children, and members of families with dependent children. The program will spend approximately $156 billion in total—$89 billion federal spending and $67 billion in state and local funding.

The CBO projects that federal Medicaid spending will grow at an average annual rate of 10.4 percent between 1995 and 2002—nearly double the 5.5 percent annual growth in total federal spending over that time period. And, the Congress in its budget resolution has proposed substantial reductions in the rate of increase in Medicaid spending—cutting the baseline growth rate by more than half—lowering the average annual growth to 4.9 percent over seven years, for total savings of $182 billion below the baseline. That is a 19 percent reduction in total Medicaid funds over this time period—and by the year 2002, federal Medicaid spending would be 30 percent below the current baseline projection.

This unprecedented reduction in Federal support for the legitimate health care needs for poor Americans is short sighted at best and potentially damaging to the very fabric of our society. We are resolutely opposed to this level of spending reductions. That does not mean we are opposed to restraining the growth of Medicaid program expenditures. This statement will contain our specific cost saving recommendations.

Current discussions of changes in Medicaid focus on two types of policy and budget proposals designed to meet these fiscal targets:

- *Federal "Cap":* Establishing some type of financial "cap" on the federal contribution to the program in order to meet congressional budget savings targets; and,
- *Flexibility:* Providing states with substantial additional flexibility in how to design and implement the program within the state.

Medicaid—one name/multiple programs

While Medicaid is a program that clearly merits improvement, reform should take into account some of the unique characteristics of this program and of the diverse populations that it serves.

Medicaid is discussed in a generic sense as a "program"—but it is in fact multiple programs meeting health and long-term care needs of some very discrete population groups.

- *Acute care:* two different types of acute care program are included in Medicaid:

  —an acute care health benefits program for cash assistance recipients (families with dependent children, and aged, blind, and disabled individuals who do not receive Medicare), and low-income pregnant women and children; and,

  —an acute care Medicare "supplemental" policy (the equivalent of a "Medigap" plan) for dual Medicare/Medicaid eligibles.
- *Long-term care:* Medicaid is the nation's major long-term care coverage program (Medicare covers just limited post-hospital nursing home stays)—including catastrophic coverage for individuals who spend-down their income and assets on long-term care services to specified levels and then become eligible for Medicaid.
- *Services for developmentally disabled:* Medicaid is a program that provides long-term support for individuals with developmental disabilities, through benefits such as intermediate care facility services for the mentally retarded.

Medicald reform

The time has come for the policy debate to move past the generalities of Medicaid reform and focus on appropriate—and separate—federal policies, and budget targets for each area, with the goal being to rationalize these three separate programs. Further, it is vitally important that policy makers proceed incrementally in these areas—establishing a long-term direction but focusing this year's action on specific steps that can be implemented and monitored, with further actions in the future. The following sections outline long- and short-term approaches for the three components.

Acute care for low-income individuals

Long-term approach: For acute care benefits, Medicaid beneficiaries should have the choice of enrollment in competing health plans under a model similar to that prevailing for large employer purchasers, and comparable to the AmHS Institute suggestions for Medicare program reform. Those Medicare reforms called for updating the program to provide beneficiaries choices in managed care and other arrangements that are now the dominant form of benefits in the private sector.

Further, there should be a strong federal role in the acute care component of Medicaid. The AmHS "Patients First"[1] plan advanced in 1991 envisioned a long-term restructuring of Medicaid, with states assuming responsibility for 100 percent of long-term care, and the federal government funding 100 percent of acute care Medicaid. In addition, "Patients First" called for eliminating Medicaid's welfare-related eligibility, and shifting to an income-based system; and a merged Medicaid, Medicare administrative structure. We recognize that this long-term approach may not be feasible in the current budget climate—but it does call for program reform and maintaining a strong federal financial commitment and role.

Short-term actions: The question is how to proceed with action this year. A number of changes should be made in the acute care program that evolves out of Medicaid.

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[1] AmHS' "Patients First" plan is the health care reform plan advanced by American Healthcare Systems in 1991.

Managed care without waivers: States should be able to implement Medicaid managed care programs, including mandatory enrollment programs, as part of their regular state plan, without having to seek a federal waiver from the Health Care Financing Administration. Such approval should be made conditional on beneficiaries having a choice of at least two competing plans, and those plans meeting appropriate health plan standards, including standards that assure the plans have the capability of meeting the special needs of the enrolled population. Once a Medicaid beneficiary has chosen a plan, states can require that the Medicaid beneficiary remain with the plan for at least one year. In addition, integrated delivery systems that meet appropriate standards should be among the alternatives offered to Medicaid beneficiaries.

Maintain adequate funding level: Medicaid reform simply will not work, especially in a more competitive health market, unless state payments for services, whether made directly to providers or to health plans, must meet minimum standards of reasonableness. In the evolving market, it will be increasingly difficult to shift costs to other payors—states simply cannot continue to underfund Medicaid benefits and rely on health care organizations to shift the costs.

Revise definition of and payment to disproportionate share hospitals (DSH): The definition of "disproportionate share" hospitals under Medicaid should be narrowed in a way that limits these to those hospitals that truly serve a "disproportionate share" of Medicaid and other low income patients. In addition, changes should be made in the current disproportionate share payment cap applicable to each state to assure federal savings.

At the same time, we need to assure that the remaining payments for disproportionate share hospitals are a direct funding stream paid from the state Medicaid program to the hospital: these funds should not be included in Medicaid payments to health plans unless the DSH hospital has agreed to such an arrangement.

Finally, states should not be able to pay more as DSH payments to state facilities than the actual costs of treating Medicaid recipients.

Anti-fraud measures: Medicaid programs should renew their commitment to fraud control. The Secretary should be directed to develop mechanisms to better monitor and prevent dual eligibility, as well as measures such as picture I.D.s and "smartcards" that would provide mechanisms to identify and track beneficiary and provider fraud.

Financial limits: Finally, it is necessary to deal with the difficult budget targets included in the Congressional budget. If the Medicaid managed care proposals, and the savings from the disproportionate share plan, do not meet agreed-upon budget targets for the acute care portion of Medicaid, then the rate of increase in federal spending could be further constrained through one of two approaches:

—a temporary reduction in the federal matching rates comparable to those enacted in the early 1980's; or,

—a cap on the rate of increase in acute care Medicaid spending per capita. Such a mechanism would require a precise definition of a "per capita" measure in order to assure equity among the states and prevent gaming. The per capita measure should be the full-time/full-year equivalent number of enrollees entitled to some minimum Medicaid benefit package.

Research and demonstrations on managed care for Medicare/Medicaid eligibles: One of the key issues for the future is implementing managed care for the elderly and disabled—including the joint Medicare and Medicaid eligibles. The Health Care Financing Administration should explore options under which managed care plans could be used for the dual Medicaid/Medicare eligible when Medicaid provides the benefits supplemental to Medicare.

Long-term care

Long-term approach: AmHS' "Patients First" envisioned turning long-term care over to the states at the same time as financing for acute care services was federalized. Given the budgetary and demographic realities of an aging population, it is appropriate to keep open options for such a state approach, but also to enhance the development of the private long-term care insurance market as well as consider development of federal financing mechanisms.

The private long-term care insurance market should be developed by extending tax-preferred treatment to long-term care insurance comparable to that available for acute care health benefits. In addition, federal financing mechanisms should be identified to finance the costs of those who will not be able to rely on private coverage. Estate taxes are one viable long-term alternative to Medicaid's current "spend-down" policies for financing long-term care. Today, those elderly individuals who are unfortunate enough to need long-term care may exhaust nearly all of their assets—while comparably situated individuals fortunate enough not to need long-

term care retain all their assets in their estate. A broadly-based estate tax could be considered as a mechanism to spread the financing more equitably.

The key for this year's policy process is not to try to make every decision required for the next seven years. Instead, policy makers should seek to set the stage for making decisions about the nation's approach to long-term care financing some time in the next five years, so that the programs can be put in place, and financed, well in advance of the year 2011 when the leading edge of the "babyboom" generation begins to reach age 65.

Short-term approach: In the short-term, the following changes should be made as part of the process to enhance the private long-term care market and to separately identify and manage the long-term care portion of Medicaid.

Private long-term care insurance: tax policy should be changed to encourage the development of the private long-term care insurance market by providing tax preference for long-term care insurance comparable to that available today for acute care insurance.

Asset transfers: Medicaid currently limits the ability of individuals to transfer their assets in order to become eligible for the program, and in particular, for nursing home benefits. The current time period during which transfers of assets are presumed to have been made in order to establish Medicaid eligibility could be extended to three years (from 30 months).

Research, demonstrations on long-term care managed care: finally, given the complexity of the long-term care issues, it is important to pursue a research and demonstrations agenda in this area in order to better inform the future policy process.

• *Managed care:* While Medicaid managed care has been extended on a fairly extensive basis to acute care services, managed care models are less well-developed in the public and private sectors for applying managed care techniques to chronic, long-term care services. Medicaid should explore demonstrations of such models, including early identification and application of managed care for those who do not become eligible for Medicaid until they "spend-down" their income and assets, typically through long nursing home stays.

• *Private coverage/public program linkages:* As the private, long-term care insurance market evolves, the linkage between private coverage and Medicaid should be explored. Incentives should be considered for encouraging those who can afford it to purchase private long-term care coverage—including measures such as delaying the onset of the Medicaid "spend-down" for individuals who have exhausted benefits under a qualified long-term care policy.

• *Financing:* As the demographic realities of an aging "baby-boom" population confront us, it will become increasingly important to conduct in-depth research on options for developing additional financing sources for long-term care services. For example, research should be conducted on mechanisms for determining whether the adult children of individuals receiving publicly supported long-term care benefits should have some obligation to share in financing their parents' care, especially in the case of children with high incomes. As with public financing, research would also be appropriate on how to link any such responsibility to the evolving private long-term care market; for example, whether purchase of private long-term care coverage could be "deemed" to meet any such shared responsibility provisions.

Federal financial constraint: a separate cap should be placed on the rate of increase in federal spending on long-term care services under Medicaid. As with acute care, two approaches should be considered to reach whatever spending target for long-term care is established by the Congress:

—a temporary reduction in the federal matching rates comparable to those enacted in the early 1980's; or,

—a cap on the rate of increase in long-term care Medicaid spending per capita. Such a mechanism would require a precise definition of a "per capita" measure in order to assure equity among the states and prevent gaming. The per capita measure should be the full-time/full year equivalent number of enrollees entitled to some minimum long-term care benefit package.

Services for the developmentally disabled

Federal Medicaid matching funds are provided for services for the developmentally disabled, largely through services in intermediate care facilities for the mentally retarded (ICF/MR) services. These funds, through which Medicaid essentially refinanced the states' traditional role in providing services for this population, should be separately identified as the third new program to evolve out of Medicaid.

Long-term approach/short-term actions: Given the states' traditional role in this area, this component of the program should be converted into a "block-grant."

• *Financial cap:* federal spending for the full spectrum of medical, social, and rehabilitation services for the developmentally disabled should be separately identified and provided to the states in the form of a block grant, with the rate of increase in federal spending capped to meet whatever budget targets are set for this component of the program.

• *State flexibility:* states should be able to use the federal funds with substantial flexibility; for example, under such a block grant, they would be able to offer home and community-based services for this population without having to resort to a federal waiver.

Conclusion

The AmHS Institute strongly supports reform of the Medicaid program, and urge you to proceed with the specific action steps we have outlined above. We would be happy to assist you.

Prepared Statement of The Consortium for Citizens With Disabilities

Mr. Chairman, we are pleased to present the views of the Consortium for Citizens with Disabilities (CCD) Health and Long term Services Task Forces on Medicaid Revisions. These task forces include over 50 national consumer, professional, health provider and scientific organizations, working to enact comprehensive health care reform that will meet the needs of children and adults with disabilities and chronic health conditions, and their families.

We thank you for making our views part of the Committee's record. This hearing provides us with the opportunity to stress the vital importance of the Medicaid program for people with disabilities, which includes individuals of all ages with physical and mental impairments, conditions or disorders, and people with acute or chronic illnesses, which impair their ability to function.

Lack of adequate and affordable insurance for acute health care needs is a critical issue for people with disabilities, many of whom have experienced first hand the myriad problems with the current system of private insurance. In particular, they are subjected to the discriminatory practices of the health insurance industry, which either refuses to insure them outright, or will only issue a policy with a pre-existing condition exclusion. For many people with disabilities and/or their families, private health insurance may be unavailable or unavoidable. Between 1989 and 1994, employer health insurance coverage of the under-65 population declined from 66 percent to 59 percent, while Medicaid coverage of this population increased from 9 percent to 14 percent. Clearly, Medicaid is a critical health care safety net for millions of poor Americans.

For those in need of long-term care services and supports Medicaid is the sole payer of last resort. Those who are categorically eligible for Medicaid can receive these services, and depending on the eligibility rules of their State, some middle-class families can receive long-term care services and supports through the Medicaid program after they have "spent down" to poverty. While private long-term care insurance is often proposed as a viable approach to paying for long-term care costs, this insurance is medically underwritten and so it is not available to anyone with a disability or serious chronic illnesses: not to a child with Cerebral Palsy, an adolescent with serious mental illness, an adult with a spinal cord injury, a 50 year old with Alzheimers Disease, or a 70 year old with a stroke. Additionally, all long-term care insurance policies currently available deny benefits to persons with mental impairments other than Alzheimers Disease.

THE IMPORTANCE OF MEDICAID FOR PEOPLE OF ALL AGES WITH DISABILITIES & CHRONIC ILLNESSES

Eligibility: Who is Covered?

The requirements of Federal law, coupled with decisions by individual States in structuring their programs, determine who is actually eligible for Medicaid in a given State. Federal law places limitations on the categories of individuals who can be covered and establishes specific eligibility rules for each category. Within these federal parameters, States are given the option to cover other categories. As a result, there is considerable variability in eligibility from state to state: individuals in similar circumstances may be automatically eligible for coverage in one State, be required-to assume a certain portion of their expenses before they can gain coverage in a second State, and be ineligible in a third State.

Medicaid provides health and long term care services for over 36 million people. There are approximately 4.9 million children and adults who are blind or disabled among the very diverse Medicaid population. According to the Health Care Financ-

ing Administration, people who are blind or disabled make up 15 percent of the Medicaid population and lead to between 31 and 39 percent of Medicaid expenditures. Most of the 4.9 million people with disabilities qualify because they are eligible for the Supplementary Security Income (SSI) program. In some states, individuals with disabilities or their families may be eligible for Medicaid because they have high medical expenses in relation to income. A portion of the women and children who qualify for Medicaid through the Aid to Families with Dependent Children (AFDC) program also have disabilities and serious, chronic illnesses.

In addition, millions of people who are elderly and have physical and mental impairments received essential services through Medicaid. Together, the Medicaid eligibility categories of "elderly" and "blind and disabled" comprise almost one-third of the Medicaid population and approximately two-thirds of the Medicare expenditures. These numbers are growing and are expected to continue to grow over the next 25 years as the population ages and as continuing improvements in medical technology are likely to increase the number of children and adults with disabilities.

Consequences of Ending the Entitlement to Medicaid

While some states have taken advantage of the options to expand Medicaid eligibility, many have not. Medicaid reforms that explicitly or implicitly end or weaken the current entitlement to Medicaid will exacerbate state variability in eligibility for federally-subsidized services. This could create significant problems both for individuals with disabilities and for states, if people and families chose to move to one state or another merely to gain access to Medicaid services.

Aggregate spending caps will lead to reductions in the number of people who can receive services because states will not be able to respond to demographic pressures and their attendant costs. While the CCD believes that capita caps are an improvement over aggregate caps, they still do not take severity of need into account. Additionally, without major reforms in the private health insurance market, increases in the number of Americans without private health insurance are inevitable. Reducing the number of people eligible for Medicaid will simply shift costs to localities and the private sector. As a result, private insurance rates will rise and hospitals will incur greater costs for uncompensated care, and people will go without needed services leading to additional costs to all in the long run.

If Medicaid is no longer an entitlement, millions of people, including those on SSI will lose access to critical health and support services. For persons with disabilities and serious chronic health conditions, the lack of services and supports may well lead to an exacerbation of existing health conditions, the emergence of additional health problems and secondary disabilities, and in some cases to inappropriate institutionalization. For individuals with long-term care needs, lack of Medicaid coverage will place unreasonable pressures on family members, many of whom will have their own economic security undermined paying for health and long-term care costs, and in some cases foregoing employment to care for relatives.

Recommendations

1. For all of these reasons, the CCD strongly oppose any Medicaid reforms—whether through block grants or caps on aggregate spending—that will result in a loss of eligibility for current categories of Medicaid beneficiaries. As you deliberate Medicaid reforms, it is essential to put a human face on the numbers you are seeking to cut: a child with mental retardation or cerebral palsey, an adolescent with a traumatic brain injury or a spinal cord injury, a young adult with serious mental illness or multiple sclerosis, a middle aged person with Alzheimer's Disease or cancer, an elderly person with a stroke or Parkinson's Disease. The acute and long-term care needs of these persons and millions of other Americans are not going to disappear just because federal funding of Medicaid has been reduced.

2. At the very least, we strongly recommend a continuation of the federally mandated entitlement to Medicaid for persons eligible for Supplemental Security Income (SSI).

Services: What is Covered?

Medicaid is an important source of federal and state funding not only for acute health care services, but also for long-term services and supports for low income persons of all ages with disabilities and serious chronic illnesses. The effective use of Medicaid funds has enabled the development of state service systems that are meeting the needs of millions of people with disabilities, helping them to become more independent.

The Medicaid program offers federal reimbursement for a wide range of services. States are mandated to offer particular services, which include: inpatient hospital services, outpatient hospital services, rural health clinic services, other laboratory and x-ray services, nurse practitioners' services, nursing facility services, family

planning services and supplies; physicians' services, medical and surgical dental services; and early and periodic screening, diagnosis and treatment (EPSDT) for individuals under age 21.

The EPSDT mandate enables the early identification and treatment of serious health and other disabling conditions. For example, it enables a child with hearing loss to receive early intervention services and provides coverage for hearing aids so that the child can develop language skills; for children with conditions such as cerebral palsy, which can impair speech, it covers the cost of augmentative communication devices, enabling these children to communicate with family members and peers.

States also have the option to choose from an array of additional services that meet specialized health care needs. The comprehensive range of specialized services for people with disabilities that states have voluntarily chosen to add to their Medicaid program include:

Outpatient rehabilitation services; Occupational, physical, and respiratory therapy; Speech-language-hearing services; Clinic services, which can include mental health services, assistive technology, and other services; Targeted case management for individuals with developmental disabilities or mental health care needs; Personal care services; Prosthetics, orthotics, and other medical equipment; Dental services; Prescription drugs; and other health professional services, often targeted to individuals with mental illness or other disabilities.

The primary source of long-term services for poor elderly individuals and younger individuals with disabilities is the Medicaid Long-Term Care (LTC) program. Services provided include institutional care, group homes, home and community-based waiver services, and community supported living arrangement services. They are used to provide a wide range of supports to individuals with significant disabilities. Approximately 85 percent of Medicaid LTC expenditures are for institutional care, including nursing home care. Only 15 percent of expenditures are for home- and community-based services. Some of the long-term care services and supports currently covered by Medicaid include:

Services in institutional and community living situations for individuals with mental retardation/developmental disabilities (e.g., Intermediate Care Facilities); Home- and community-based long term care, services, and supports (e.g., respite care); Inpatient mental health services for children under age 21; Day treatment and habilitation; Personal assistance, including 24 hour emergency assistance, appropriate to carry out activities of daily living in or outside the home; Homemaker/chore services incidental to the provision of such personal assistance services; In the case of an individual with a cognitive impairment, assistance with life skills; Communication services, including, but not limited to, assistance with interpreting, reading, writing and the use of communication devices, augmentative communications devices and/or telecommunication devices; Work-related support services, including but not limited to, ongoing services to assist an individual in performing work-related functions necessary to obtain and perform a job, and personal services while on the job; Mobility services in and out of home, including but not limited to: escort and driving, and/or mobility assistance on public transportation; The purchase or lease of assistive technology devices for use by individuals with disabilities; selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing or replacing such devices; Coordinating and using other therapies, interventions or services with assistive technology devices (e.g., those associated with existing education or rehabilitation plans or programs); training or technical assistance for an individual with disabilities or where appropriate, the family and personal assistants; and Modifications to the principal place of abode of the individual.

As a result of this coverage, many programs that were initially state or locally-financed were able to expand to serve more people with disabilities. State mental health services and school-based health services are also funded in some states with Medicaid dollars. Federal leadership and funding has also enabled states to move forward to develop home- and community-based services under waiver programs, to cover children with disabilities (e.g, through the use of the so-called "Katie Beckett" waiver on eligibility), and to provide personal care services as an alternative to nursing home care. These positive steps should not be compromised by diminished federal requirements regarding the use of Medicaid funds. Rather, when federal Medicaid funds are used, they should be used for these critical services, which for many people with disabilities, can mean the difference between life and death, between institutional living and freedom, between inactivity and productivity.

Proposals to block grant or cap the Medicaid program, with no federal requirements to provide health, rehabilitation and home-and community-based long term care services and supports, will inevitably lead to a reduction in critical services for millions of people with disabilities.

Recommendations

1. The full array of mandatory and optional services currently provided through the Medicaid program must continue to be available for reimbursement.
2. Critical services, such as those provided through the EPSDT program, must continue to be mandated.
3. The home- and community-based services currently available only through waivers under Section 1915 and other sections should be made simple state option. This would relieve the states of much paperwork burden, increase flexibility but also maintain oversight protections to assure that Medicaid funds are used appropriately.
4. Home-and community-based services and supports, such as community supported living arrangements and psychosocial rehabilitation for individuals with mental illness, should be expanded. Current Medicaid disincentives for home- and community-based care should be replaced with incentives for the provision of these services.
5. States must continue to be required to finance comprehensive accute and long-term care services and supports. They should be given flexibility and direction to promote the use of home-and community-based long-term care services and supports. The current bias for institutional services must be ended.

FEDERAL REQUIREMENTS UNDER BLOCK GRANTS OR CAPPED PROPOSALS

State Maintenance of Effort

If funds are given to the states with no requirements whatsoever, these funds may be used for purposes other than providing currently available Medicaid services. If states are allowed to determine how to spend the funds, the health and long-term care service needs of people with disabilities may well be neglected.

Recommendations

1. The use of Medicaid funds under a block grant must be restricted to the provision of services currently provided through the program.
2. States must be required to maintain at least their current level of funding of Medicaid services.

Federal Oversight and Consumer Protections

An important feature of the Medicaid program, particularly for people with disabilities and specialized health care needs, is that Medicaid law and regulations include strong protections that for 30 years have provided beneficiaries with legal and other tools that enable them to receive the health care to which they are entitled.

The rules are specific and cannot be changed except through a public legislative or administrative process. Beneficiaries have legal recourse if their care is denied or if their rights are abridged. Generally, States must develop statewide plans and must meet minimum standards on eligibility, scope of services and procedural protections. The purpose of these protections is to enhance and assure access to necessary health care.

In the ICF/MR program, for instance, to participate in Medicaid and receive reimbursement, States are required to assure that these programs provide appropriate treatment, a safe environment, and qualified staff. The ICF/MR program has served and continues to serve as a major incentive for states to improve conditions in their institutions in order to qualify for Federal Medicaid payments. The ICF/MR option was quickly selected as a service category by many States. By 1977, 43 states were covering the service, and by 1990 all States were covering ICF/MR services.

Medicaid involvement, through federal oversight, provided states with the incentive to maintain minimum standards for residential programs. The availability of ICF/MR funding provided States with an alternative to placing persons with developmental disabilities in Medicaid-funded nursing homes. ICF/MR funding is used to support large institutions as well as small residences with as few as four people. Federal oversight of state monitoring has resulted in improved conditions and increased protections for some of our most vulnerable citizens. Their rights must not be abridged by the elimination of federal standards.

Important current protections include:

- Individuals must be given an opportunity to apply for Medicaid without delay and to be assisted by a representative, if needed, during the application process.
- States are required to inform applicants and beneficiaries of the benefits available and of their rights and obligations.
- Applicants have a right to notice and an administrative fair hearing before an impartial hearing officer when claims for assistance are denied or not acted upon promptly.

• If States intend to take action that is adverse to an individual, they must give timely notice of the intended change to the applicant or beneficiary. Final decisions must be made within 90 days of the request for a hearing.

• States are restricted in requiring beneficiary copayments. Copayments must be nominal in amount.

Additional protections that promote the quality of care delivered to Medicaid beneficiaries include:

• The amount, duration and scope of services cannot be reduced on the basis of one's condition, diagnosis or type of illness. Thus, beneficiaries are protected from discrimination on the basis of their health or disability.

• Coverage must be available statewide.

• Generally states must give beneficiaries freedom of choice among participating providers (states can waive this requirement for certain alternative delivery systems).

• Under Medicaid's Early and Periodic Screening, Diagnosis and Treatment program, the largest child health program in the country, states are required to make preventive screening available and to arrange for "such other necessary health care, diagnostic services, treatment and other measures... to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services...." This provision ensures that States will provide all medically necessary services to children with disabilities, even if the services are not currently covered in the State's program.

• States must set payment rates to providers that are adequate to assure beneficiaries reasonable access to services of adequate quality. State payment rates must be sufficient to attract enough providers so that care and services are available to Medicaid beneficiaries at least to the extent they are available to the general population in the geographic area.

• Beneficiaries receiving long-term care in nursing and other facilities have clear rights to obtain quality care. Among other things, nursing homes must assess patient needs, follow a comprehensive care plan, protect patients' funds and provide sufficient care and services so that patients "can attain or maintain the highest practicable physical, mental and psychosocial well-being." Residents must be given notice and opportunity for a hearing before they can be transferred.

Recommendations

1. Existing protections and due process regulations for Medicaid recipients must be retained and information on these protections must be made available to all recipients and providers.

2. Federal oversight and standards must be maintained, particularly for institutional care in facilities such as nursing homes and intermediate care facilities for individuals with mental retardation and developmental disabilities.

MEDICAID MANAGED CARE AND PEOPLE WITH DISABILITIES

For most of Medicaid's history, recipients, like people with private insurance, received their care through a fee-for-service system. In recent years, escalating costs have led most states to establish some form of managed care system for Medicaid beneficiaries. In 1994, 23 percent of Medicaid beneficiaries were enrolled in managed care. The majority of these enrollees are low income women and their children who are recipients of Aid to Families with Dependent Children (AFDC). Although 18 states have offered managed care plans for people with disabilities since 1993, most have exempted people with disabilities and specialized health care needs, and so less than one percent of this population is currently enrolled in them. Several waiver programs, however, are targeted for Medicaid beneficiaries with specific conditions, such as mental illness, AIDS, substance abuse disorders, and diabetes.

Concerns about the Ability of Managed Care to Adequately Serve Persons With Complex and Specialized Health Care Needs

Many states have chosen not to include individuals with disabilities in their mandated managed care programs because of uncertainties regarding adequate service delivery. Doubts are increasingly expressed about the ability of managed care plans to realize savings when serving individuals with disabilities. Many states have little experience with managed care for high-risk populations. Because of limited enrollment, most of the studies of Medicaid enrollees in managed care do not include people with disabilities. Therefore, it is difficult to determine whether moving high-risk Medicaid populations into managed care will save money for the states.

Regardless of the lack of experience with high-risk populations, given current trends in Medicaid expenditures, it is likely that many states will continue to expand enrollment in managed care for Medicaid beneficiaries, including people with

complex and specialized health care needs. Kentucky is currently seeking federal approval to expand its KenPAC section 1915(b) program to include people with disabilities and Tennessee is covering persons with disabilities as part of its section 1115 Medicaid project, TennCare. Beneficiaries must enroll in capitated managed care organizations for all but long-term care services. TennCare is preparing to expand coverage to additional groups needing mental health services. Dually-eligible Medicare/Medicaid recipients are typically excluded from mandatory enrollment.

The Consortium for Citizens with Disabilities recognizes that well run managed care plans have the potential to improve access to care for the Medicaid population by promoting preventive and early intervention services; the integration and coordination of care; and by reducing the fragmentation often found in the fee-for-service system. However, we have major concerns about the incentives in managed care to underserve populations with extensive or specialized health care needs, as well as the use of a managed care approach for long term services.

Problems with Managed Care

Changing from a Medicaid-fee-for-service system to Medicaid managed care has led to many of the same problems facing enrollees in managed care plans in the private sector. Research has shown that managed care leads to a decline in the use of specialist services. While inappropriate and unnecessary utilization should be reduced, there are concerns that appropriate and necessary utilization will also be reduced with negative consequences for persons with complex and specialized health care needs. In many cases, the failure to provide appropriate specialized treatment can lead to longer and more expensive periods of acute illness with attendant high hospital costs, and to the development of secondary disabilities, which additionally limit a person's ability to be independent.

Individuals with severe disabilities and serious chronic illnesses are more likely to depend on specialist care, even for services that are generally considered as primary care. A study in Wisconsin's Medicaid managed care program found that only half of the Medicaid beneficiaries who had a family member with specialized health care needs thought that the HMO could meet those needs due to barriers to referring to specialists.

There are many problems associated with current Medicaid managed care waiver programs. These include: (1) a lack of comprehensive evaluations; (2) a lack of involvement by beneficiaries and their advocates in the development of waiver applications or in the implementation and evaluation of waivers; (3) a lack of planning and provisions to assure that services are available for people with complex and specialized health and long-term care needs; (4) a failure to address issues related to transitioning people with complex and specialized health care needs into managed care plans; (5) a lack of grievance procedures and disenrollment provisions for persons who are dissatisfied with the services available; and (6) an absence of clear provisions to assure that adequate and appropriate services will continue to be provided at the end of the waiver period.

In addition, many Medicaid recipients in managed care programs have also lost important protections they had in the fee-for service system. Federal Medicaid law has always included important minimum quality of care and consumer protection standards. Many states that have obtained permission from the U.S. Department of Health and Human Services to implement Medicaid managed care programs have been allowed to proceed without important quality-of-care standards and consumer protections. Thus, most Medicaid managed care programs do not have the important protections that Medicaid beneficiaries have had for over 30 years. The absence of required standards and protections may have negative consequences for individuals with chronic, complex, and special health care needs.

Cost Savings are not Assured

In both the Senate and the House, discussions about ending the entitlement to Medicaid and reducing federal payments for this program, managed care is seen as a primary means to lowering costs to make up for the reduction in federal payments. Yet, as the recent Kaiser Foundation report noted, managed care is unlikely to result in large cost savings, particularly if elderly people and people with disabilities are enrolled. Because these populations frequently have complex and costly health and long-term services needs, determining adequate capitation rates and finding managed care plans that are both willing and able to adequately serve these populations will likely prove difficult.

To address all of these concerns, the CCD makes the following recommendations.

Recommendations

• People with disabilities and serious chronic illnesses who have complex and specialized health and long-term service needs should be exempted from mandatory enrollment in Medicaid managed care plans.

• Medicaid managed care plans that serve this population should include provisions for assuring continuity of care, including specialty care.

• Covered services should include all those needed to treat acute and chronic conditions, to prevent secondary complications and deteriorations in functioning, and to maintain health.

• Medicaid managed care plans should include provisions that allow specialists to act as gatekeepers when appropriate for persons with serious, complex and specialized health care needs.

• As research and demonstration projects, Medicaid waiver programs must include a comprehensive evaluation component. Evaluations should include indicators of health, functional outcomes and consumer satisfaction that are appropriate for the population served.

• All Medicaid managed care plans should have an option for enrollees to access out-of-network services for an additional copayment.

• States should consider input from the disability and rehabilitation community when developing their Medicaid managed care networks.

• Physicians in Medicaid managed care plans must be adequately compensated and not placed at inordinate financial risk.

• Medicaid managed care programs must not include disincentives, financial or otherwise, to the provision of services in home and community-based settings when appropriate.

• States must assure that private managed care plans meet requirements to assure their financial solvency. There should be federal and state regulations to assure the financial solvency of any private managed care plans. Entities must require evidence of financial solvency.

• Medicaid managed care plans should include effective and timely grievance procedures and disenrollment provisions.

• Managed care plans must provide participants with clear information on policies, procedures, and grievance mechanisms, and must assure consumer participation in the development of these procedures and mechanisms. Reviews must be conducted in a timely manner and an independent ombudsman program should be required.

• For persons with disabilities, particularly persons with mental disabilities, strong marketing safeguards are necessary to protect them from inappropriate and misleading marketing practices by managed care entities, such as offers of "prizes" and "rewards" for enrolling.

• Managed care plans must have timely procedures for obtaining independent second opinions when covered benefits are denied for any reason, including a judgement that they are not "medically necessary." These second opinions must be considered in any grievance review.

Conclusion

The Medicaid program is the largest source of federal and state funding for services and individuals with disabilities. Federal Medicaid funds comprise 40 percent of all federal aid to the states. These funds have been used by states to supplement state dollars so that services and supports can be expanded. To meet the needs of people with disabilities, states have elected options which cover such services as community living, assistive technology, mental health services, therapies, respite care, and home nursing. With federal oversight and protections that safeguard the health, safety, and rights of children and adults with disabilities, states have been able to leverage federal and state funds in ways that benefit millions of people.

This investment in children and adults with disabilities is critical if we are to ensure that they receive the health, rehabilitative, and other acute and long term care services and supports they need to achieve and maintain independence and to reach their full potential.

The CCD believes that current Congressional proposals to block grant the Medicaid programs, thus changing the existing relationship between the federal and state governments, have the potential to place people with disabilities in jeapordy. Proposals to block grant Medicaid would eliminate the critical "entitlement" status of the program; are likely to lead to an inequitable distribution of federal funds to the states; and will have a substantive negative impact on state budgets and their ability to pay for critical services for children and adults with disabilities.

In conclusion, the CCD asserts that it is imperative that any proposals to change the fiscal relationships between federal and state government, including changes in

federal funding formulas or expenditures, must not have a negative impact on the health and well being of people with disabilities. For many individuals with disabilities or specialized health needs, access to Medicaid acute and long term services is critical to their health and their ability to live more independent and productive lives in the community. The Task Force also asserts that federal and state protections and standards must be included in managed care programs in order to protect the health, safety, and rights of people with disabilities and specialized health needs.

We want to thank the Committee again for this opportunity to present our views and our concerns related to the Medicaid program. We look forward to working with you to ensure that any reforms to the program have a positive, not a negative, impact on the lives of individuals with disabilities.

PREPARED STATEMENT OF EDNA FARIS, ALEXANDRIA, VIRGINIA

My name is Edna Faris. I am here today because I want you to understand what Medicaid means to me and what large cuts could do to me.

I am 76 years old. I live in a modest, two-bedroom apartment in Alexandria, Virginia. Life has been very good to me and to my family. I am married to a wonderful man, Wilson, whom I call "Moose." We were married in 1943 and have been married 52 years.

Moose was born poor, put himself through college with a football scholarship and a job, and served his country as a Naval officer in World War II. After he left the Navy, he decided to be a teacher. Moose worked hard for 23 years as a science teacher and a football coach in the Fairfax County Schools. For 20 of those years, he supplemented his modest teacher's income by working every evening at a supermarket. At Moose's insistence, I stayed home to be with our children. This paid off handsomely as our children have really done us proud. Together we raised two wonderful children, a daughter and a son. We have five beautiful grandchildren, including a grandson who bears his grandfather's name.

Since he retired in 1978, we have lived within our means on his pensions and our social security. Since I did not work outside the home, my social security is very small.

Moose was diagnosed with Alzheimer's disease in 1990. I took care of him at home for three years. I helped him with eating, dressing, and bathing; our income did not allow me the luxury of hiring someone to assist with his care. Even though it was an unexpected drain on our modest saving, for at least one year I spent $35 plus transportation each day, 5 days a week, to take Moose to an Adult Day Care Center as the doctors felt it was therapeutic for him. My children were also very supportive helping me as much as they could in view of their full-time employment. They took their father one weekend a month so that I would have some respite.

His condition became progressively worse and he needed constant supervision, otherwise he would wander off. Finally in February 1993, after returning home from cancer surgery, he became combative toward me, and he was rehospitalized.

The doctors told me he needed to go to a nursing home. Our entire family was heartbroken but neither we nor our children could afford private care at home. The most difficult decision I made in my life was to place him in a nursing center in Arlington.

I visit him every other day except when I am sick myself, which even though I'm physically fit, has occurred several times since 1993.

When Moose entered the Nursing Center, we were told to apply for Medicaid because we sure didn't have the money to pay for a nursing home. I believe we would have had to pay $120 a day at that time. I understand that it now costs $133 a day.

Medicaid counted all of our assets and since it wasn't much, Medicaid allows me to keep them. Medicaid says I can keep $1,230 plus some extra from our total income for my housing costs, but the rest of his pension, approximately $1,500 a month, goes to help pay the nursing home.

When you don't have much money, it takes all you have to keep going. It is very difficult to make ends meet even with Medicaid help, but I don't know what I would have done if there wasn't a Medicaid program that would pay for his care.

I am normally not emotional about many things, but I am very emotional about this subject.

Although we have been hard working citizens, we have no choice but to rely upon Medicaid to pay for his care.

We were unfortunate. My husband has the wrong disease. If he required lots of doctors and surgery, Medicare and insurance would cover most of his bills, but be-

cause Alzheimer's requires long term care, we have no choice but to look to Medicaid for help.

I believe nursing home care in Northern Virginia costs about $48,000 a year. Even if we used everything we had, it would not have paid for more than three months in a nursing home, and he has been there for almost 2½ years. I cannot give him the care he needs at home, and all of our income could not pay for his care, much less leave me with anything to live on.

And should he die, I will not even have the benefit of the life insurance he took out years ago. I had to cash in the largest policy for $10,000 and use it for living expenses even though it would have paid a higher amount if I could have kept it until my husband dies.

And, even though my children have told me that I am welcome to live with them, like many senior citizens, I am too fiercely independent and love my children too much to impose myself on them. In conclusion, I am afraid if Medicaid is cut my husband could become ineligible, or that the program could severely limit the services he gets. I say to you, I couldn't face worrying every year about whether his care will be paid for. It sounds like the lottery to me, and I don't have anything more that I can risk.

I have a hearing impairment. My hearing is almost totally gone and I communicate with others through sound if they are close by and speaking loudly, or by lip-reading. In this grand room both may be difficult. If you have any questions, I will try to communicate in such a manner but I may need to have the questions repeated or written down.

Thank you.

STATEMENT OF STEVE SEIBERT, CHAIRMAN, PINELLAS COUNTY COMMISSION

I am Steve Seibert, Chair of the County Commission in Pinellas County, Florida. My purpose in providing testimony to the panel is to emphasize the concern that we at the county government level have with regard to the Medicaid block grant funding proposal.

In Pinellas County, as in many other counties, our social services program for health care is designed to take care of the indigent population who have no other resources for health care. Using local tax revenues, we act as the "safety net" for these needy individuals who do not receive assistance from any federal or state program, who have no health insurance, and whose income is at or below the federal poverty level. For these people, the County is the provider of last resort.

It appears to us that the proposal reflected in the joint budget resolution passed by Congress in May of this year will have the ultimate effect of providing less health care coverage for persons who may qualify for Medicaid, and also will result in fewer persons being qualified for Medicaid benefits. It seems clear to us that when federal contributions to the Medicaid program are "capped" at the levels proposed in the budget resolution, the result will be an increase in the number of persons in need of medical care who will look to County government to provide those services once funded by the Medicaid program.

Over the past ten years, there has been an increasing level of concern within our community about the growing health care needs of our low-income population, about the increasing cost of health care, and about the shrinking resources of government at all levels to meet those needs.

We have also recognized, that even with the Medicaid program operating as an entitlement program at *current* levels, and despite the county-provided health care program, which has also essentially operated as an entitlement program—meaning that we have never denied benefits to qualified persons because of budgetary constraints—still, there is a significant health care deficit in our community. The health care needs of many residents are not being met for a variety of reasons—because they are uninsured, cannot afford it, or find themselves in a catastrophic situation due to accident or illness.

Recognizing the complexity of the problem of unmet health care needs, County government has taken the lead in bringing together a broad-based community group to participate in a project called "Choices for Community Health."

This project enlists the support of the community, and especially of those serving community health needs, to help solve this countywide problem. The project seeks to promote partnerships among the business community, health care providers, governmental agencies, and the general public; and it encourages creative methods for addressing local health care needs.

While our "Choices for Community Health" project has not come up with all the answers for all the problems, my point in telling you about this effort is to make

you aware of the critical role that County government plays in the area of health care. It is not solely a financial role; it is also a leadership role. On the financial side, we do levy local taxes to fund our own indigent care program, at a cost of $15 million annually; we also contribute to the state's share of the Medicaid program; our local cost for Medicaid match is $7 million annually. There are other health care programs that we contribute to—and when you add it all up, including our pre-hospital care through our Emergency Medical Services program, the total is about $50 million annually from local tax dollars, for health care.

The reason we are so deeply concerned about your intention to cap federal contributions to Medicaid is simply this; Medicaid is only *one* of the tools in the tool kit for dealing with the health care needs of our community. We do not believe Congress has solicited enough input from those of us on the "front lines" trying to grapple with very complex and much broader health care issues.

We believe Congress may be making the decision to end the entitlement approach and shift to a block-grant approach without fully taking into consideration the ramifications this action will have on an already serious situation at the local level.

You have already heard testimony in earlier hearings about the problems with the proposed funding formula, i.e., how it will disproportionately impact certain states, including Florida. I am sure you have also been made aware that in Florida, 70% of Medicaid spending goes for the elderly and the disabled.

I would like to bring that impact to the local level, and describe what we fear will be the scenario in Pinellas County, where we have 226,000 permanent residents over the age of 65, and within that number, 111,000 permanent residents over the age of 75.

Pinellas County will lose an estimated $942 million over the seven-year period from 1995 to the year 2002, due to the capping of federal contributions to Medicaid.

Total Medicaid expenditures for Pinellas County eligibles this current year will be $337 million. We are talking about roughly a 40% loss of federal support over the seven-year period.

County government simply cannot absorb this loss of federal funds. And yet, on a very human level, the fact is that there are already 7,367 Medicaid recipients in nursing homes in our County. When the entitlement nature of the Medicaid program ends, we are concerned about the limited alternatives, or lack of *any* alternative, for many of these residents of our county. The seven-year loss for nursing home payments alone is estimated at over $300 million.

It seems to us that, absent any positive strategy for health care reform at the national level, the proposed Medicaid reductions will surely exacerbate the health care problem, and potentially precipitate a crisis situation for those of us at the local level to deal with.

We would urge you to consider these comments, and the supplemental information which we are submitting with this testimony. We would further urge you to take into consideration the experience and expertise available to you from local governments across the nation, especially the large urban counties, which are already deeply involved and heavily invested in indigent care service delivery. We would like to see some mechanism established for involving the local public sector in the decisionmaking process on this issue that we expect will impact us so dramatically.

Finally, I would like to express my sincere appreciation for your invitation to testify before the panel, and to offer any assistance we may be able to provide as you move ahead with the tasks before you.

HISTORICAL PERSPECTIVE—PINELLAS COUNTY "CHOICES FOR COMMUNITY HEALTH" PROJECT

Fall 1990—Pinelas County Government establishes the Medically Needy Task Force to assess the Social Services Department health care program for the indigent. Task force is comprised of community leaders and is given responsibility for recommending methods of improving the delivery of services.

January 1991—A technical committee is established and assigned primary responsibility for determining population served, assessing the delivery of services, and recommending corrective action.

Fall 1991—Medically Needy Task Force recommends that the County's health care program be expanded and that a special taxing district be established to fund the expansion.

January 1992—The BCC holds a public hearing to ascertain public reaction and opinion concerning the possibility of placing a tax item referendum on the March or October ballot to support the expansion of health care services to the indigent population. Public overwhelmingly opposes increasing taxes. BCC decides not to hold referendum.

April 1992—BCC contracts with McManis and Associates to complete an indepth assessment of health care services provided by the Department of Social Services.

August 1992—McManis study is completed and recommendations are reported to the BCC. BCC requests that the Department of Social Services prepare a corrective action plan based on the recommendations.

Pinellas County Department of Social Services is chosen to implement a pilot project "Strategic Choices", a collaborative effort between the National Association of Counties and the IBM Corporation. Strategic Choices is a business oriented problem solving strategy that emphasizes partnership efforts.

October 1992—Strategic Choices process implemented at Department of Social Services with initial focus on assessment of department's services and delivery with suggestions for improvement. Ultimate goal is to extend the process to the community to solicit their expertise and support in solving a county-wide problem.

March 1994—Strategic Choices project extended to the community. Over 60 individuals representing the business community, medical profession, community advocacy groups social service agencies, and interested citizens attend the first meeting. The emphasis is on developing a unified, integrated medical care delivery system for the entire county.

Summer/Fall 1994—Meetings continue and core leadership council is formed with the project becoming a community effort rather than a Pinellas County Government project. Project is renamed: "Choices for Community Health" to reflect the fundamental philosophy.

Spring/Summer 1995—Choices for Community Health applies for incorporation and non-profit status. Plans are underway to select a business leader to take command of the project. The University of South Florida is contracted to complete a community health assessment. Public Relations Committee works diligently to promote a positive image of the project to the community.

PINELLAS COUNTY MEDICAL CARE PROGRAMS—NON-MEDICAID ELIGIBLE

Medical Assistance:

Medical services are provided to individuals: who require medical treatment and whose income is equal to or less than 100% of poverty level and whose assets are equal to or less than $2,000 (HH 1); $3,000 (HH 2 or more).

Types of services: on-site primary care clinic services; prescriptions; full-service dental; specialist services; home health care; prosthetics; emergency room payment; inpatient care; and kidney dialysis.

Mobile Medical Unit:

Medical care provided to individuals: who are homeless and need medical care.

Types of services: primary care; referrals to specialists; inpatient care; and vaccinations.

COUNTY HEALTH CARE PROGRAMS
[Fiscal year 1993–1994]

Persons Served:	
Outpatient assistance	8,350
Inpatient hospital	1,808
Total	10,158
Clinic Treatments:	
Primary care clinic visits	8,472
Mobile medical clinic visits	3,645

PINELLAS COUNTY DEPARTMENT OF SOCIAL SERVICES

People we serve:

Annette is a 61 year old female employed by the YMCA. Her hours vary, but are generally below 40 hours per week and she has no medical insurance. Due to a previous history of uterine cancer, it is necessary for her to remain under continued medical care; however, because of her pre-existing condition, she is unable to afford the cost of private medical insurance. Because of medical services rendered by this department Annette is able to access appropriate medical care without entering the realm of disability programs and is therefore able to remain active in the work force.

A 42 year old truck driver broke his neck in a swimming accident and needed both financial assistance and medical services. The Department provided medical care and therapy and the client was able to attend Vocational Rehabilitation while we assisted with living expenses. As a result, he was able to attend Tampa College and complete Paralegal training. He maintained contact with the social worker and

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regularly reported his grades—usually a 4.0 average and then invited us to is graduation.

Joan came to the Department while working as a live-in companion to an older woman. She had no income and no health insurance. She was diagnosed with breast cancer and began receiving medical benefits and financial assistance from us. Due to her illness, her physician felt that it would be more beneficial for her to reside in an ACLF facility but we were unable to find an ACLF willing to accept her. Through the efforts of the social worker and the staff at Everybody's Tabernacle, the HEP accepted Joan into their residence. Joan applied for Social Security Disability benefits and as a result of intervention by our Social Security Specialist, Joan was awarded benefits and retroactive Medicaid to cover much of her medical bills. Joan is doing well and volunteers full-time at Everybody's Tabernacle.

James represents the type of client that is known to almost every social service agency. He is a person who is virtually illiterate, has both mental health and physical health problems that are insufficient to qualify for state or federal disability programs. Unfortunately, he is socially unemployable. He has been receiving assistance since 1980 and the Department continues to work closely with Gulf Coast Legal Services in an effort to help him receive Social Security benefits.

Anthony is a well educated 60 year old who came to the Department with severe bi-polar disorder. He had a strong denial system built up and his disorder manifested itself in an extremely difficult manic phase which made dealing with him very difficult for the social workers as he was often unpleasant. However, due to the persistent efforts of the social work staff using various methods of communication and the intervention of our Social Security Specialist, we were able to help Anthony get treatment at Directions and Social Security benefits awarded. He remains in treatment at Directions.

Through the concerted efforts of our St. Petersburg Clinic Medical Care Coordinator and our Field Investigation Unit, we were able to transport to Bay Pines Hospital a veteran in need of continuous IV therapy and chemotherapy. Allen had been discharged from Moffitt Cancer Center after surgery and was immobilized in a full leg cast. He resided in a second floor apartment and was unable to reach a phone. Bay Pines would not accept him as he did not have his discharge papers. The Social worker contacted the Veterans Service office who secured his discharge papers. We then attempted to have Allen transported to Bay Pines by ambulance; however, the hospital would only admit him if he arrived by taxi. After contacting the Bay Pines social worker and arranging for Allen's admission, we called the St. Pete Fire Department to ask for their help in moving him from his apartment. The Fire Department sent firefighters to carry Allen from his second floor apartment to the taxi sent by our Medical Care Coordinator. Allen was then taken to Bay Pines Hospital and later admitted for treatment.

These are just a few examples of the types of situations with which we deal on a daily basis. It is important to note that in most instances, the Department coordinates efforts with a variety of agencies and organizations in an attempt to treat our clients with dignity and to assist them in obtaining services and benefits specific to their circumstances. This often entails work above and beyond the scope of our programs.

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